

WARM

**Women's Access to Reproductive Care
in Medically Underserved Areas**

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Executive Summary

WARM — Women's Access to Reproductive Care in Medically Underserved Areas — is part of the project Promoting Gender Equality through Research on Access to Reproductive Care and Education on Gender-Based Stereotypes, implemented by the Institute for Philosophy and Social Theory (IFDT), University of Belgrade, with the support of the OSCE Mission to Serbia. The project documents how women in Serbia's medical deserts access and experience reproductive and maternal care, with particular attention to rural settlements and Roma communities.

Although Serbia formally guarantees reproductive and maternal care through universal health coverage, desk research and fieldwork show that these guarantees are not evenly translated into real, continuous care for women who live far from urban centers, depend on fragile transport networks, or experience poverty, discrimination and disability. In these areas services exist in laws and organizational charts, but women encounter them as distant, fragmented and sometimes unsafe. This gap is what the project terms maternal and reproductive deserts.

Using the AAAQ framework — availability, accessibility, acceptability and quality — the project combined a desk review of laws, policies and statistics with qualitative ethnographic fieldwork. Fourteen in-depth interviews were conducted with women aged 19 to 74 in seven localities across two regions: villages around Kikinda in Northern Banat and villages in the Zaječar catchment in eastern Serbia. Both regions display weak staffing in gynecology and pediatrics, long travel times, irregular or non-existent public transport and high out-of-pocket costs relative to local incomes.

What the research found

At the level of availability and accessibility, the research documents a cumulative dismantling of rural health infrastructure. In several villages ambulant buildings are derelict and no longer in use, pharmacies are absent and residents have no local healthcare of any kind. Where services nominally exist, they are staffed by rotating or near-retirement doctors working morning-only hours. Emergency response is unreliable, public transport has largely disappeared, and administrative district boundaries force women to travel past the nearest hospital to reach their assigned facility.

At the level of acceptability and quality, women describe non-consented interventions in labor, routine use of fundal pressure, denial of pain relief and separation from newborns without medical justification. Humiliating treatment in gynecological encounters leads many women to avoid preventive care altogether. Medical documentation sometimes records examinations that were never performed. Complaints are widely seen as futile, as disciplinary committees are perceived as closed professional circles. These problems fall most heavily on Roma women, women with disabilities, older adults and low-income households. Roma women describe racist dismissal, trivialization of serious symptoms and structural exclusion from the information and services that would allow them to navigate care safely.

Alongside these failures, the research identifies fragile anchors of good practice: individual providers who explain everything and treat patients with dignity, and neighbors and family members who step in as informal drivers, translators and health navigators. These solidarities are indispensable but unevenly available and vulnerable to burnout and migration.

What needs to change

Maternal and reproductive deserts are produced at the intersection of workforce distribution, transport, financing, gender norms, racism, ableism and everyday clinical practice. The report proposes six strategic lines of action:

1. **Rebuild a predictable local maternal and child health presence**

Define minimum service packages for villages, provide incentives for longer postings of key staff, and establish cross-district protocols that allow patients to use the nearest facility.

2. **Protect bodily integrity and clinical safety**

Prohibit routine fundal pressure, standardize informed consent for inductions and pain relief, and limit unjustified separation of mothers and newborns.

3. **Make respectful communication and accurate documentation a standard of care**

Introduce codes of conduct on speech and behavior, align records with reality, and pilot recall systems for critical follow-ups.

4. **Treat discrimination against Roma women as a systemic issue**

Combine mandatory anti-racism training with strengthened Roma health mediator programs and co-created accessible health information.

5. **Make disability and age-related protections effective in everyday practice**

Fully cover essential assistive devices for low-income and rural households, develop home and community-based services, and enforce priority access rules.

6. **Open up governance and accountability**

Strengthen independent patient-rights mechanisms and use qualitative evidence and complaints as inputs to quality improvement and policy.

These recommendations are designed as realistic entry points rather than exhaustive solutions. Implemented gradually but coherently, they would help shift the burden of adjustment away from women who currently stretch their bodies, budgets and networks to compensate for institutional gaps, and toward the institutions that bear responsibility for ensuring that reproductive and maternal care is available, accessible, acceptable and of good quality for all.

Introduction

"You can never just go and feel normal there. Instead, you feel like you've gone to the vet." (Nina, 55, Brusnik)

This is how a woman living in a village in eastern Serbia describes her experience of seeking gynecological care at the nearest public health facility. She is not describing an exceptional incident. She is describing the ordinary. Thirty-six villages around Zaječar have no gynecologist. The single gynecologist at the town's health center takes appointments from the 26th of each month only, and many women wait four weeks for a slot. For those without a car, there are two buses a day, timed to the school schedule, with no service at all during holidays. This is not an exceptional corner of Serbia. The WARM project — Women's Access to Reproductive Care in Medically Underserved Areas — began from the recognition that accounts like hers, and landscapes like this one, are neither anecdotal nor marginal, but evidence of a systemic failure to deliver reproductive and maternal care to women in Serbia's medical deserts.

WARM is part of the project Promoting Gender Equality through Research on Access to Reproductive Care and Education on Gender-Based Stereotypes, implemented by the Institute for Philosophy and Social Theory (IFDT), University of Belgrade, with the support of the OSCE Mission to Serbia. It is designed to generate gender-sensitive evidence on how women in Serbia's medical deserts navigate reproductive and maternal health services, with particular attention to rural and Roma communities.

Although reproductive care is formally guaranteed through universal health coverage, desk research conducted in the first phase of the project showed that these guarantees are not evenly translated into usable, continuous care for women who live far from urban centers, depend on fragile transport networks, or experience poverty and discrimination. Statistical data and legal frameworks suggest a relatively dense network of institutions, but when examined more closely through staffing ratios, opening hours, travel time and out-of-pocket costs, clear pockets of under-provision and under-use emerge. In these areas reproductive and maternal services exist on paper, yet women experience them as distant, fragmented or unreliable. This gap is what the project terms maternal and reproductive deserts.

Reproductive care is time-sensitive and recurs across a woman's life: contraception, pregnancy check-ups, birth, miscarriage care and routine screening. When services are far away or hard to reach, women pay the price in time, stress and risk. They are more likely to juggle childcare, travel with infants, take unpaid time off work and plan around limited bus schedules. Even when care is nominally free, the real costs accumulate: transport, missed wages and long waits. Barriers are not the same for all women. Adolescents, Roma women, women with disabilities and those in rural or peri-urban areas face additional obstacles including documentation requirements, stigma and disrespectful treatment. Some deserts are social rather than purely geographic: a clinic may be nearby, but if staff are dismissive, there is no privacy, or no interpreter is available, women still cannot use the service safely or with dignity.

The desk research phase identified two regions as particularly affected by medical and maternal desertification: the wider Zaječar area in eastern Serbia and the villages around Kikinda in Northern Banat. Both are characterized by demographic decline, under-resourced primary care and large catchment areas served by a small number of gynecologists and maternity facilities. Both also include Roma settlements and households with disabled members, whose encounters with the health system are shaped by long-term poverty, racism and ableism. These regions are therefore not only remote in a geographic sense but situated at the intersection of spatial and social marginalization.

Aims of the study

The study pursues two central aims. The first is to document how reproductive and maternal care are actually accessed and experienced in medically underserved regions, using the AAAQ framework of availability, accessibility, acceptability and quality as a guiding analytical lens. Rather than assuming that the physical presence of services guarantees access, the study examines how women move through the system, which services they avoid or postpone, and how they describe feeling safe or unsafe in contact with providers and institutions.

The second aim is to produce actionable recommendations addressed to national policy-makers and to actors at district and municipal level, including health centers, local governments, and civil and private sector stakeholders who can influence transport, information, complaint mechanisms and local support.

Structure of the report

The analysis that follows is organized around four interconnected themes: institutional and organizational barriers to care, respectful maternal care in a broad sense, experiences of discrimination and unequal treatment, and the specificities of Roma women's encounters with reproductive and maternal services. Together, these themes offer a grounded picture of what maternal and reproductive deserts look like in practice and point toward concrete pathways for making care more accessible, acceptable and safe for the women who live in them.

Theoretical and Contextual Groundings

KEY DEFINITIONS

Medical deserts

Areas where population healthcare needs are unmet partially or totally due to lack of adequate access or improper quality of healthcare services caused by: (i) insufficient human resources in health or (ii) facilities, (iii) long waiting times, (iv) disproportionate high costs of services or (v) other socio-cultural barriers.

Brinzac et al. (2023), *European Journal of Public Health*, 33(5), 785-788. <https://doi.org/10.1093/eurpub/ckad107>

Maternity care deserts

Regions with no obstetric care facility or obstetric providers, or regions located further than 50 miles from critical care obstetric services, in which the lack of access to risk-appropriate maternity services is a leading contributor to disparities in maternal morbidity and mortality.

Meredith, Steimle and Radke (2024), *BMC Health Services Research*, 24, 682. <https://doi.org/10.1186/s12913-024-11135-4>

Maternal and reproductive deserts (this study)

Areas where reproductive and maternal health services formally exist but are experienced by women as distant, fragmented, unpredictable and sometimes unsafe, due to the intersection of workforce shortages, transport gaps, financing barriers, gender norms, racism, ableism and everyday clinical practices. The concept extends the medical and maternity desert frameworks by foregrounding women's lived experience and the social dimensions of inaccessibility — including stigma, discrimination and disrespectful care — as constitutive of the desert condition.

Definition developed for this study (WARM, 2025)

The Serbian context: between formal guarantees and lived inequalities

Serbia's legal framework strongly endorses the right to health and gender equality. The Constitution of the Republic of Serbia (Službeni glasnik RS, no. 98/2006) establishes the right to health protection as a fundamental entitlement. The Law on Health Care (Zakon o zdravstvenoj zaštiti, Službeni glasnik RS, no. 25/2019) and the Law on Health Insurance (Zakon o zdravstvenom osiguranju, Službeni glasnik RS, no. 25/2019) provide the institu-

tional and financial framework for universal coverage. The Law on Patients' Rights (Zakon o pravima pacijenata, Službeni glasnik RS, no. 45/2013, amended 25/2019) establishes a catalogue of patient entitlements including the right to quality care, informed consent, privacy and protection from discrimination. The Law on Gender Equality (Zakon o ravnopravnosti polova, Službeni glasnik RS, no. 52/2021) prohibits discrimination in healthcare and mandates gender-sensitive services (Pantovic et al., 2025). Strategies on public health, gender equality and reproductive health further commit the state to reducing regional and social disparities. In practice, however, desk research conducted for this project showed that staffing maldistribution, high out-of-pocket expenditure and weak transport systems create substantial gaps between these formal commitments and women's actual access to care, particularly in primary care and preventive services (Bjegovic-Mikanovic et al., 2019; Pantovic et al., 2025).

For women in rural areas, geographic and infrastructural barriers intersect with broader patterns of inequality. The Gender Equality Index for Serbia documents persistent rural-urban disparities across multiple domains. In the health domain specifically, rural women face barriers in access to healthcare services including preventive and reproductive care, due to geographic distance, insufficient infrastructure and limited availability of medical staff. These structural disadvantages are compounded for women from minority groups, women with disabilities and those living in poverty, for whom the costs of accessing nominally free services frequently render them inaccessible in practice.

Medical deserts in Serbia: existing evidence and what this study adds

The only published quantitative study mapping medical deserts across Serbian districts is Mandić-Rajčević and Šantrić-Milićević (2022), which used health system inputs, processes and outputs to identify districts with inadequate population access to primary healthcare. The study developed a Multiple Criteria Scoring System drawing on indicators for four types of physicians — general practitioners, pre-school pediatricians, youth pediatricians and gynecologists — and five dimensions of unmet need: financial barriers, waiting times, lack of personal time, long distance and COVID-19 related obstacles. It found that medical deserts partially overlapped depending on the criteria used, with accessibility gaps identified in four to ten districts and performance gaps in three. The study did not focus specifically on reproductive or maternal care, nor did it document women's lived experiences of accessing or being denied care within those districts.

This study builds directly on that quantitative mapping and extends it in three important ways. First, it focuses specifically on reproductive and maternal care rather than primary healthcare in general, recognizing that access to gynecological services, antenatal care and childbirth has distinct time-sensitivity, gendered dimensions and consequences that aggregate health system indicators cannot fully capture. Second, it applies an explicitly gendered lens, examining not only whether services are available and physically reachable but whether they are acceptable and safe for women — dimensions that require qualitative investigation rather than supply-side counting. Third, it centers women's own narratives,

including those of Roma women, women with disabilities and women in the most underserved localities, whose experiences are invisible in both quantitative datasets and administrative records. Where the Mandić-Rajčević and Santrčić-Milicević study asked where medical deserts are, this study asks what it is like to live in one, and what needs to change.

Taken together, these three extensions reflect a conviction that geographic and statistical maps of desertification, while necessary, are not sufficient for policy. Understanding why women avoid care, how they manage without it, and what would make it genuinely usable requires sustained attention to their lived experience.

Respectful maternal care and obstetric violence

A growing body of research has documented women's negative experiences during childbirth and reproductive care in Serbian public institutions. Studies point to systematic overuse of non-recommended interventions such as routine episiotomy and fundal pressure, limited access to effective pain relief, lack of privacy, and frequent reports of verbal abuse or neglect during labor (Centar za mame, 2015; Stanković, 2014, 2017; Matejić et al., 2014; Sekulić, 2025). These findings resonate with WHO's concern that mistreatment and disrespect in facility-based childbirth undermine women's trust in health systems and deter them from seeking care in subsequent pregnancies (WHO, 2016; Bohren et al., 2015).

The World Health Organization defines respectful maternity care as care organized and provided in a way that maintains dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth (WHO, 2016, 2018). Respectful maternity care is therefore not an optional quality enhancement but a core dimension of safe care, operating at the interpersonal level through how providers speak to and handle women, and at the structural level through policies on pain relief, birth companions, confidentiality and complaint mechanisms (Bohren et al., 2015; Shakibazadeh et al., 2018).

Feminist and human rights scholars increasingly use the term obstetric violence to describe harmful practices in antenatal, intrapartum and postnatal care, defined as an umbrella term covering verbal abuse, neglect, non-consented interventions, unnecessary use of technology, disregard for pain and exclusion of women from clinical decisions (Sekulić, 2025). The term remains contested in some medical circles in Serbia, where professional associations have publicly rejected its broad application (Sekulić, 2025). This study treats both respectful maternity care and obstetric violence as necessary analytical lenses: the former keeps attention on normative standards and practical pathways for change, while the latter foregrounds the power inequalities and institutional cultures that shape how childbirth and reproductive care are delivered.

Intersectional vulnerabilities

Barriers to respectful reproductive care are not evenly distributed. Roma women, women with disabilities, adolescents and women living in poverty face layered forms of exclusion that intensify the effects of medical desertification. Existing research on Roma women's health in Serbia documents higher levels of unmet need, poorer self-reported health outcomes and heavier reproductive burdens, in contexts of deep poverty and social exclusion (Cvorovic and James, 2017). Studies on discrimination in maternal healthcare in Roma communities in Serbia and neighboring countries show that Roma women are more likely to experience denial of care, disrespectful treatment and inadequate information, with measurable consequences for the timeliness and adequacy of antenatal and intrapartum services (Janevic et al., 2011, 2017).

Women with disabilities face a related but distinct set of barriers: architectural inaccessibility, lack of adapted equipment, provider assumptions about their reproductive lives, and limited availability of accessible information on reproductive rights. These barriers frequently intersect with rurality, low income and gender norms, resulting in very low uptake of screening and preventive services and heightened vulnerability to coercion in reproductive decision-making (WHO, 2017).

Even where a clinic is physically nearby, if women expect to be shamed, disbelieved or refused care because of their ethnicity, disability or age, the service becomes what this study terms a social desert. The ethnographic focus on women's narratives and on the micro-politics of encounters with providers is therefore not a methodological preference but a necessary step in understanding how structural inequalities are reproduced in everyday reproductive care.

Methodological Approach: From Mapping to Ethnography

The study is structured in two phases. The first phase consisted of a desk review synthesizing Serbia's legal and policy frameworks, national statistics, and peer-reviewed and grey literature to map where reproductive and maternal deserts are likely to be most pronounced. This analysis assessed availability and accessibility through staffing ratios, caseloads and travel-time proxies, while explicitly treating acceptability and quality as dimensions requiring ethnographic investigation. The desk phase identified two priority geographies: villages around Kikinda in Northern Banat and villages around Zaječar in eastern Serbia (Batut, 2024).

The second phase, on which this report is based, is qualitative and ethnographic. The study adopts the AAAQ framework, as elaborated by the UN Committee on Economic, Social and Cultural Rights, as its analytical lens (CESCR, 2000). The framework insists that reproductive health services must be available in sufficient quantity, physically and financially accessible, culturally acceptable and of good quality. Its four dimensions guided both the selection of field sites and the structure of the analysis.

	Availability	Accessibility	Acceptability	Quality
Key question	Is the service there?	Can women reach and use care?	Is care respectful and appropriate?	Is care safe, competent, continuous?
Desk inputs	Facility counts, OB-GYN supply	Distance/time proxies, women per OB-GYN	Limited proxies (e.g. complaints)	Structural proxies (staffing, equipment)
Field inputs	Actual hours, staff, stock-outs	Real costs, waiting times, barriers	Dignity, privacy, discrimination, stigma	Continuity, referral, timeliness, safety
Key rationale	Access is theoretical without supply	Free care blocked by time and cost	Disrespect and stigma suppress demand	Quality ensures access translates to outcomes

Table 1: AAAQ dimensions of the study (CESCR, 2000)

Site selection: why Zaječar and Kikinda

The two regions were selected because they represent compounded disadvantage across multiple indicators of reproductive and maternal care access, making them strategic sites for understanding how desertification operates in practice.

In the Zaječar district in eastern Serbia, the staffing picture for women's healthcare is among the most severe in the country. According to 2023 data from the Institute of Public Health of Serbia, there are only 9.1 physicians dedicated to women's healthcare per 100,000 women aged 15 and over in the district, compared to a national average more than double that figure. In the same year, Zaječar recorded approximately 10,935 women of reproductive age per gynecologist, compared to around 4,114 in the best-staffed district. Thirty-six surrounding villages have no gynecologist at all, and the town's health center operates

with a single gynecologist. Appointments open only after the 25th of each month, meaning many women wait close to a month for a slot. For residents of surrounding villages, public transport consists of at most two buses per day timed to school schedules, with no service during school holidays. Since the local elections in summer 2025 and the ensuing crisis of local government, several villages have had no scheduled public transport at all (Đokić, 2025; NIN, 2025). Preventive mobile visits to village clinics, which once brought gynecological services directly to rural women, ceased after COVID-19 and have not resumed. Rural facilities are dilapidated, some closed, with outdated instruments and periods without heating (Batut, 2024; Markovic, 2025).

In Northern Banat, the staffing situation is relatively stronger at the district level, with 13.7 physicians in women's healthcare per 100,000 women in Kikinda according to 2023 data, and early antenatal coverage reaching 88.9% in the first trimester. However, these aggregate figures mask significant operational gaps. Analysis of the publicly available shift schedule for the Primary Care Center in Kikinda for September 2025 found that only 45% of all possible shifts were staffed. Just five days in the month had full two-shift coverage, seventeen days had only one shift, and eight days had no gynecological coverage at all, with entire weekends typically unstaffed. Village health outposts operate exclusively in morning hours on weekdays, with only alternate weekend coverage. Community follow-up is weak: the average number of home-visiting patronage visits per pregnant woman is just 0.5. Both regions also include significant Roma settlements and households with disabled members, whose encounters with the health system are shaped by compounding disadvantages of poverty, discrimination and geographic marginalization. These regions are therefore not only remote in a geographic sense but situated at the intersection of spatial and social exclusion (Batut, 2024).

Together, the two regions offer a picture of desertification that combines quantitative underservice — too few providers, too few hours, too little transport — with qualitative inaccessibility rooted in discrimination, stigma and disrespectful care. This combination made them the most appropriate sites for a study designed to capture both dimensions.

Sample and data collection

Fieldwork combined semi-structured narrative interviews, walk-along interviews and participatory micro-mapping of routes to care in the two selected regions. Sampling was purposive and sought maximum variation across life course, parity, socioeconomic position and forms of vulnerability, including rural isolation, low income, disability and caregiving for disabled family members (Palinkas et al., 2015; Patton, 2015). The sample includes women at the beginning of their reproductive lives, mothers of small children, women with complex reproductive histories and infertility treatment, caregivers of disabled children, and older women with decades of experience of the health system. Several participants are Roma, and some live with disability themselves or in households with disabled family members.

In total, the team conducted fourteen in-depth interviews with women aged 19 to 74 across seven localities: Novo Miloševo and Bočar in Northern Banat, and Rgotina, Brusnik, Klenovac, Nikoličevo and Veliki Izvor in eastern Serbia. All interviews were conducted face to face, in settings chosen by participants, and lasted between 60 and 120 minutes. Interviews were complemented by informal conversations and walk-alongs that allowed the research team to observe routes to care and the physical condition of health infrastructure firsthand.

Region	Locations	Interviews	Age range	Focus
Northern Banat	Novo Milosevo, Bocar	7	19 to mid-40s	Young women; mothers of small children; women juggling paid work with caregiving and travel to services
Eastern Serbia	Veliki Izvor, Nikoličevo, Rgotina, Brusnik, Klenovac	6	31 to 74	Women with long reproductive histories; caregivers of disabled children; older women; women in structurally underserved villages

Table 2: Sampling strategy

Participant profiles are provided in full in Annex 2.

Analytical approach

Interview material was analyzed using a thematic, inductive approach informed by the AAAQ framework and the literature on respectful maternity care and obstetric violence. Four interconnected themes emerged as central: institutional and organizational barriers, respectful maternal care, discrimination and unequal treatment, and Roma women’s experiences of maternal and child health services.

Throughout the analysis, women’s narratives are treated not as anecdotal illustration but as a necessary complement to administrative indicators, particularly in contexts where gender-sensitive, ethnically disaggregated and disability-disaggregated data are incomplete or absent (Pantovic et al., 2025). Their accounts of pregnancy, birth, miscarriage, infertility treatment and long-term caregiving reveal dimensions of acceptability and quality that coverage rates and procedure counts cannot capture. An ethnographic approach allows the study to follow women across space and time, from home to bus stop, from waiting room to examination room, attending simultaneously to their strategies and to the structural constraints under which both they and their providers operate (Creswell and Poth, 2018; Green and Thorogood, 2018).

Ethical considerations

The study received ethical approval from the Ethics Review Board of the Institute for Philosophy and Social Theory, University of Belgrade, on 7 October 2025 (approval no. 1111/2025). All participation was voluntary and based on informed consent. Participants are identified throughout by pseudonyms. Data are stored in accordance with applicable ethical and legal standards.

Theme 1: Institutional and Organizational Barriers

Across both research regions, women encounter not a functioning healthcare system with isolated gaps, but a landscape of cumulative institutional withdrawal where predictability, proximity and continuity of care have been systematically eroded over decades.

Across both researched regions, residents describe a long, uneven but recognizable dismantling of rural healthcare. What used to be a territorially grounded system — village clinics, doctors who stayed for decades, workplace medical units, pharmacy counters within walking distance, predictable bus lines to the nearest hospital — has thinned into an irregular, fragmented landscape. In both Northern Banat and Eastern Serbia, this retreat is experienced as a cumulative erosion of institutional presence, care and predictability. What remains is a system heavily dependent on mobility, individual resources and personal networks.

1.1 Disappearing local healthcare: infrastructure, staffing and emergency gaps

Residents of both Northern Banat and eastern Serbia describe a recognizable pattern of institutional retreat that has unfolded in two broad waves. The first is associated with post-socialist restructuring in the 1990s and early 2000s, when factory closures eliminated workplace-based medical units, maternity wards were centralized to larger urban hospitals, and village doctors began operating on reduced schedules. The second, more recent wave is characterized by ageing staff and non-replacement: across the studied localities, key figures in primary and women's healthcare are either already retired and working on a temporary basis, or within a few years of retirement, with no successors in place.

What remains in villages such as Bocar and Novo Miloševo are skeletal outposts: ambulante open a few mornings per week, staffed by rotating or near-retirement doctors, without resident pediatricians, mental health professionals or basic diagnostic equipment. In Brusnik, Klenovac, Nikoličevo and Veliki Izvor the situation is more severe: the ambulante buildings are derelict and no longer in use, pharmacies are absent, and residents have no local healthcare infrastructure of any kind. For these villages, access to any form of primary care requires travel.

The consequences are concrete and cumulative. Families with young children or chronic conditions are dependent on private providers and out-of-pocket payments for specialist care. Emergency response is described across interviews as dangerously unreliable: ambulances take hours to arrive, weekend and afternoon coverage is largely absent, and families report being explicitly instructed to transport critically ill relatives themselves. Severe cas-

es including stroke, suspected appendicitis and serious accidents require families to mobilize their own vehicles and networks rather than rely on a functioning emergency system.

Preventive care has deteriorated in parallel. Screenings are delayed for months, equipment is frequently broken or outdated, and patients are sometimes asked to purchase their own basic medical supplies. One participant from Novo Miloševo recounts being told to buy her own swabs for a diagnostic test, collect the sample at a specified time, and then personally transport the biological specimen across town to a laboratory:

"She said, 'Come on Tuesday so I can take your swabs, but you have to go and buy them.' I said, 'Excuse me, what am I supposed to buy?' and she replied, 'Swab sticks.'... 'You'll take the swabs once we do them and carry them to the laboratory yourself.' And I told them, 'So I'm supposed to walk around Novi Bečej with these swabs and take them to the lab. What if I mess it up on the way, what if something gets in?'" (Vanja, 33, Novo Miloševo)

This account illustrates the absence of essential supplies alongside a broader dynamic in which responsibility for fundamental components of care is displaced onto patients, exposing them to risk while signaling the depth of institutional retreat.

Staffing instability compounds infrastructural decline. Participants across all localities describe a revolving door of temporary placements and short-term postings that prevents the formation of sustained therapeutic relationships. The few providers remembered positively are almost invariably older, near or past retirement age, and described precisely because their presence has been consistent:

"He's close to retirement, but he's a real doctor. Unfortunately, there are fewer and fewer like him. He stayed until 4 p.m. and examined every last patient, which is rare. The others usually leave at 1, saying 'that's it for today.'" (Veronika, 74, Rgotina)

Without continuity, care becomes transactional rather than relational. Chronic patients drift between providers, acute needs compress into already narrow service windows, and preventive care effectively disappears because it requires planning around schedules that may not materialize. As one participant from Novo Miloševo noted plainly: "Many times, I went there, took one look, turned around, and went back home." (Ana, 45, Novo Miloševo)

1.2 Access barriers: mobility, time and administrative obstacles

Even where infrastructure formally exists, reaching and navigating it presents a substantial second layer of exclusion. Across the seven localities, participants describe a healthcare landscape in which mobility, scheduling and administrative clarity have become primary determinants of whether care is actually obtained.

Public transport in Northern Banat has contracted to a near-symbolic presence. Bus services are minimal, timed to school schedules, and effectively non-functional for medical purposes: a single morning departure, no afternoon return, and complete suspension

during school holidays. Residents who cannot drive, including elderly, disabled and low-income women, are left dependent on informal arrangements or taxis that represent a significant share of monthly income.

In eastern Serbia the situation is more severe. Many villages retain only a single early-morning school bus that arrives in Zaječar too late for administrative or medical tasks and disappears entirely during holidays. Since the local elections in summer 2025 and the ensuing crisis of local government, several villages in the district have had no scheduled public transport at all (Đokić, 2025; NIN, 2025). Train service is described as unreliable and unsafe. The result is that for routine appointments, prescription collection and emergency care alike, residents depend on neighbors, informal drivers or taxis:

"Transport is a problem, especially now... we don't have a bus. The two of us don't drive anymore, because of our age and everything else... We pay for a taxi that costs 1,000 dinars one way from Rgotina to Zaječar... We even had a pharmacy until about four years ago, and they closed it. Now, for a single medication that might cost 150, 200, 500 dinars... we have to pay 2,000 dinars for a taxi just to go and buy that medicine." (Veronika, 74, Rgotina)

Waiting times impose a further barrier that disproportionately affects women with caregiving responsibilities or inflexible working hours. Participants report waiting three to four months for Pap smear results in Northern Banat and being told that an ultrasound appointment would be available the following year in Klenovac. These delays function as structural deterrents to preventive care, particularly for women who must arrange child-care, take unpaid leave or coordinate around limited transport windows for each visit. As Zorka (63) from Veliki Izvor observed when asked how long waits affect daily life: "Who even thinks about lunch? We set that whole day aside for this, that's just how it is."

Administrative barriers add a further layer of exclusion. Jurisdictional rules prevent residents of several Northern Banat villages from using geographically closer facilities in Kikinda or Bečej, requiring instead long journeys to Zrenjanin. A similar pattern operates in eastern Serbia, where villages located closer to Bor are nonetheless assigned to Zaječar for public healthcare. Participants note that in Northern Banat, medical staff show some flexibility in accommodating patients across district lines. In the Zaječar-Bor area, enforcement is considerably more rigid.

Insurance gaps create additional vulnerability during life transitions. One participant in Novo Miloševo described several months without health insurance coverage caused by administrative delays in the pension system, leaving her unable to access prescribed medication through public channels and forced to pay privately while awaiting a bureaucratic decision she could not accelerate:

"Right now it's more important for me to get the pension sooner. Fine, I guess for a month and a half or two nothing will happen to me — I'll buy the medication once or twice myself, or however many I need." (Olga, ~60, Novo Miloševo)

The understated resignation in this account reflects a broader pattern in which women absorb the costs of institutional dysfunction without expectation of redress.

1.3 The erosion of the human interface: communication, tactical navigation and informal solidarities

Beyond infrastructure and access, participants describe a subtler but equally consequential dimension of institutional retreat: the erosion of the relational quality of care. In a system under chronic staffing pressure, the interpersonal encounter between patient and provider has been compressed, routinized and in many cases stripped of the communicative elements, including explanation, acknowledgment and continuity, that participants identify as constitutive of care itself.

Women across both regions describe interactions marked by dismissiveness and depersonalization. Providers are perceived as oriented toward reducing their patient load rather than addressing clinical need:

"They look at you like you're not really welcome. They're just trying to get you off the list so they don't have so many obligations toward you. If something is urgent, they just send you on to someone else and, so to speak, consider their job done, without giving you what you actually need." (Ana, 45, Novo Miloševo)

In response to a system perceived as unresponsive, participants describe developing tactical behaviors to secure attention. Some report exaggerating symptoms to be taken seriously. Others describe enlisting family members to perform urgency on their behalf. One participant recounts how, after receiving contradictory diagnoses and being dismissed by multiple providers, her aunt devised a strategy for a clinic visit: they would perform distress in order to compel the gynecologist to conduct a proper examination. Only after this performance was a biopsy ordered and her condition correctly identified and treated. That a woman should need to stage an emergency to receive standard diagnostic care reflects how thoroughly the ordinary mechanisms of patient-provider communication had broken down.

These tactical adaptations redistribute access not according to clinical need but according to individual confidence, social networks and willingness to escalate, disadvantaging precisely those women who are most isolated, least informed or most deferential to medical authority.

Where formal services have receded, informal solidarities have partially filled the gap. Neighbors share taxi costs, organize group trips for prescriptions and provide transport for emergency care. Family members act as navigators, interpreters and advocates within hospital settings. In Veliki Izvor, participants describe a local patronage nurse whose practice extended far beyond her formal remit, visiting patients at home after surgery, providing injections for post-cardiac patients, and conducting wound care across the village. Her eventual reassignment left a void that no formal service has filled:

"That woman helped us so much, not just us, the whole village... She alone, a woman and a health worker... I pray to God they bring her back so the clinic can work the way it used to." (Zorka, 63, Veliki Izvor)

These informal networks are fragile: dependent on particular individuals, vulnerable to burnout, migration and retirement, and unevenly available across the population. Women with stronger social networks, family support and financial resources can draw on these solidarities more effectively than those who are isolated, elderly or economically marginal.

Theme 2: Respectful Maternal Care — Bodies, Words and Relationships

Women's accounts of pregnancy and birth in both regions reveal that quality of care cannot be measured by clinical outcomes alone. It is felt in how bodies are handled, what information is withheld, and whether a woman is treated as a subject of care or an object of procedure.

2.1 Bodily integrity and clinical safety: from enduring to being protected

Women in both regions describe a narrow corridor between a manageable birth and a traumatic one. When things go wrong, their language is strikingly physical: climbing, pushing, tearing, breaking a tooth from clenching. These accounts correspond to what the international literature identifies as obstetric violence, understood as an umbrella term covering non-consented interventions, unnecessary use of force, disregard for pain, verbal abuse and exclusion of women from decisions about their own care (Bohren et al., 2015; Sekulic, 2025).

In Veliki Izvor, Zorka (63), mother and legal guardian of her adult daughter Mila, recounts a pattern of dismissal that began during pregnancy and culminated in a traumatic birth. Throughout Mila's pregnancy, repeated episodes of fainting and bleeding were attributed by different doctors to attention-seeking behavior rather than investigated clinically. During labor, fundal pressure was applied, and the baby was immediately separated from the mother without clear medical justification. A psychiatrist was called, and the child was placed in foster care before Mila had any opportunity to breastfeed or establish contact:

"In pregnancy we were all the time: emergency, ward, emergency again. She would faint, bleed from the nose. One doctor says, 'She is spoiled, she wants attention,' another gives some tablets and sends us home." (Zorka, 63, Veliki Izvor)

In her account, obstetric trauma, psychiatric labelling and enforced separation from the newborn form a single continuous event rather than a sequence of discrete clinical decisions. Protecting bodily integrity in this case would have required recognizing the clinical significance of Mila's symptoms during pregnancy, reconsidering the birth plan accordingly, and treating mother-baby separation as an exception requiring justification rather than a default response to psychiatric involvement.

In Novo Miloševo, bodily integrity is equally central to Vanja's (33) account of preterm labor at 33 weeks. When her waters broke unexpectedly, she was transported an hour by car to

a hospital in Zrenjanin, the administratively assigned facility, despite Kikinda being geographically closer. She describes being left fasting and in pain for hours before being moved to the delivery room, where an injection was administered without explanation:

"My waters broke, but I had no contractions. They put me in a room and said: 'Wait.' I lay there all day without food, just tea. In the evening, they moved me to the delivery room and gave me some injection to make the contractions stronger. I don't even know what it was. I clenched my teeth so hard I broke a tooth from clenching. Only there I realized the other women were getting epidural. No one had ever told me that exists. I cursed the day I didn't take it, but how can you ask for something you don't know about?" (Vanja, 33, Novo Miloševo)

This account raises two distinct problems: the use of uterotonic drugs without informed consent, and the systematic withholding of information about pain relief options. Vanja's ignorance of epidural anesthesia was not a personal knowledge gap but a consequence of a system that did not consider it necessary to inform her.

There are also accounts of care experienced as protective. Ivana (31) from Veliki Izvor draws a clear distinction between different maternity facilities based on the quality of presence and explanation rather than on technology alone:

"In Niš they explained every step to me, the anesthetist talked to me all the time. In Zaječar it was rougher, more like on a conveyor belt, but they still did their job. In Knjaževac I really felt safe, they monitored me, they did not rush. You see the difference when you wake up and someone is there, and when you wake up alone in the corridor." (Ivana, 31, Veliki Izvor)

Her distinction points to something the quantitative literature on maternal outcomes tends to obscure: that safety, as women experience it, is constituted through communication, presence and attention as much as through technical competence. This aligns with the WHO framework on respectful maternity care, which defines quality care as inseparable from dignity, informed choice and continuous support during labor and childbirth (WHO, 2016).

2.2 Communication, consent and everyday dignity

If the previous section concerns what is done to women's bodies, this one concerns what is said to them and what is left unsaid. Across both regions, women remember specific sentences word for word, years after the encounters in which they were spoken.

In Novo Miloševo, Vanja recalls a remark made by a doctor during a pelvic examination. When she expressed that she was in pain and could not comply with the examination position, the doctor responded: "What, it hurts now, and when you were lifting your legs earlier it didn't hurt." The comment is simultaneously sexualized and moralizing, turning past consensual sexual activity into a justification for dismissing pain during a clinical procedure. Women do not need the vocabulary of obstetric violence to identify this as humiliating and professionally unacceptable.

In Brusnik, Nina (55) offers a sharp comparison between different hospital environments that captures a broader pattern of depersonalization in overstretched facilities:

"You can never just go and feel normal there... Instead you feel like you've gone to the vet. It's horrible. In Niš I felt like a person. They spoke to me, explained what they were doing, asked if I agreed. Here in the district hospital I felt like at the vet: no one looks at you, they shout 'Next, next.'" (Nina, 55, Brusnik)

Her metaphor captures an entire regime of non-recognition: no names, no eye contact, no explanation. The same woman, describing the same body and the same clinical needs in different institutional settings, experiences an entirely different standard of care, produced solely by the practices of those institutions.

Medical documentation emerges across interviews as a further site where women's experiences are overwritten by institutional narratives. In Klenovac, Jelena (48) describes arriving at an emergency unit in severe pain, receiving a blood pressure check, an infusion and an injection, and then reading her discharge letter to find an account that bore little relation to the actual examination:

"She had written it like she examined me from head to toe. I said to myself: she didn't examine even a third, not even a quarter of what she wrote here. But, okay, I felt better, what can I do, to complain now... I went home, I don't like hospitals anyway." (Jelena, 48, Klenovac)

The discrepancy between the written record and the actual encounter carries practical consequences. When a discharge letter states that a patient was examined thoroughly, any subsequent complaint or complication can be dismissed by reference to the chart. The woman's embodied knowledge of what occurred is overwritten by a written narrative that serves institutional rather than patient interests.

A similar misalignment between documentation and reality appears in Novo Miloševo, where a woman near her due date was given a referral not to a maternity ward but for kidney treatment, because the examining doctor misread the signs of late pregnancy as symptoms of renal disease. She arrived at the maternity hospital in Kikinda in labor, carrying a referral that classified her as a kidney patient. The staff response underlines the potential consequences of documentation that does not correspond to clinical reality. In this case the error was caught immediately, raising the question of how often it is not.

The pattern of closed disciplinary mechanisms extends beyond individual encounters. Across interviews, participants who had experienced or witnessed serious clinical harm consistently described the formal complaints process as inaccessible in practice. Disciplinary committees are perceived as staffed by colleagues of the accused, and forensic experts as drawn from the same professional circles, leaving families with little confidence that pursuing accountability would produce any outcome other than institutional self-protection. This perception, widespread across both research regions, functions as a structural deterrent to complaint and contributes to the normalization of poor practice.

2.3 Relational continuity and advocacy

In the context of staff shortages, rotating doctors and closing village ambulante, sustained relationships with particular providers and the advocacy work of families and neighbors function as informal anchors within an otherwise fragmented system.

In Novo Miloševo, Ana (45) describes her gynecologist in Novi Bečej as a rare constant across twelve years:

"I've been going to the same doctor there for twelve years. She followed my pregnancy. She's from a village near here; she can 'go down' to our level, explain to you what's what. If you don't understand, she explains it again. When you have someone like that, you don't feel so lost. You know who to call." (Ana, 45, Novo Miloševo)

Her words illustrate how much women value continuity and cultural proximity in making clinical advice comprehensible and trustworthy. In a maternal desert, having a known provider is a safety mechanism rather than a preference.

For families living with disability, advocacy is a continuous rather than occasional requirement. In Nikoličevo, Teodora (31), who has profound bilateral hearing loss, describes the practical implications of navigating a health system without adequate communication support:

"Nothing is close. For hearing aids we go to Bor, for check-ups to Zaječar, sometimes to Niš. My parents or my husband must always come, because I cannot hear well; they have to listen and ask. If we didn't push, if we didn't go after it, nothing would move. You can't just sit and wait for them to care." (Teodora, 31, Nikoličevo)

Her family is performing navigation, translation and emotional labor that the system does not provide. Respectful care for Teodora is inseparable from institutional recognition of the advocates around her.

In ageing and depopulating villages, horizontal solidarity between neighbors constitutes a further layer of informal support. These relational practices, whether vertical between patient and provider or horizontal between neighbors and family members, partly cushion the effects of maternal deserts. They are, however, unevenly distributed. Women with family advocates, personal contacts within the health system and strong community ties fare considerably better than those without. The informal infrastructure of care that sustains access in these regions is simultaneously indispensable and precarious.

Theme 3: Discrimination and Unequal Treatment

Discrimination in reproductive and maternal care operates through clinical routines, administrative structures and blocked accountability mechanisms that systematically disadvantage women, people with disabilities, older adults and low-income households.

Across both research regions, discrimination and gender-based violence in the health system appear not as isolated incidents but as patterned and normalized practices embedded in everyday routines, local politics and the distribution of resources. They take the form of direct exclusion, symbolic stigmatization and structural denial of access to services. These mechanisms disproportionately affect Roma families, persons with disabilities and women, especially pregnant women and mothers, but they also shape care for older adults and low-income households more broadly.

3.1 Gender discrimination and structural violence in reproductive health and motherhood

Across both research regions, reproductive health emerges as a consistent site of gendered discrimination. Women repeatedly describe encounters with gynecologists and hospital staff as hostile, dismissive or degrading, leading them to avoid preventive care altogether. In Brusnik, Nina (55) draws a direct line between the quality of interpersonal treatment and her willingness to return for routine checks: "They are terrible... The behavior is catastrophic. And then you do not want to go to the gynecologist." What appears in administrative statistics as non-attendance is, in practice, a rational response to felt humiliation. The barrier to preventive examinations is produced by the institutional environment, not by women's lack of knowledge or motivation.

This pattern is reinforced by clinical practices that bypass basic diagnostic standards. Several women recount being prescribed medication during pregnancy without tests, explanation or discussion of side effects. In Novo Miloševo, one participant describes being told to take blood-thinning medication to "fix the blood" without any laboratory analysis or risk assessment. Women are positioned as passive recipients of clinical decisions, and their bodies managed for institutional convenience rather than individual safety. Risk is shifted onto them and their unborn children while the reasoning behind clinical choices remains opaque.

A related pattern concerns high-stakes reproductive decisions made without adequate diagnostic basis. Across interviews in Northern Banat and in Brusnik, women refer to a visiting doctor who, according to multiple accounts, advised pregnant women against continuing pregnancies based on a quick clinical impression rather than test results. In one

case discussed during an interview, the woman sought a second opinion, received different advice, continued the pregnancy, and gave birth to a healthy child. Individual clinical authority substitutes for diagnostic protocol, and women are expected to comply even when the consequences concern the continuation of a pregnancy.

Discrimination also operates through the structure of financing. Several participants draw an explicit contrast between their experiences in public and private settings, observing that respectful treatment, thorough examination and clear explanation become reliably available when care is paid for out of pocket. As women in Novo Miloševo put it: “when you pay, behavior is fine, hygiene is fine — for money, everything is possible.” Dignified treatment is experienced as a commodity rather than a standard. Women relying on public institutions encounter neglect, verbal abuse and disrespect, while those who can afford private services receive attention and care. The stratification of reproductive health by income produces unequal access to both clinical safety and basic dignity.

In the most consequential cases, this stratification has fatal outcomes. In Rgotina, Sonja (37) recounts how her family lost a newborn because a timely caesarean section was not performed despite prolonged and stalled labor. Afterwards, other women told the family that they should have paid for the procedure. Medical intervention is framed as something that can be activated by informal payment. The public system does not formally deny care, but the absence of a timely procedure that would likely have been available to those with resources reveals the logic underlying the system: reproductive safety is contingent, and families who cannot or do not know how to pay are expected to absorb poorer outcomes as normal.

Even when the problem concerns child health rather than obstetric care, the same dynamic applies. In Novo Miloševo, Ana (45) describes being told that her daughter’s enlarged tonsils, which cause choking and breathing difficulties at night, could be operated on privately for around 800 euros. For a household living on modest incomes, a clear pediatric indication becomes a personal financial obstacle. The public system remains passive until a private pathway is activated, and responsibility for securing access to care is displaced onto the mother.

Administrative procedures reproduce gendered hierarchies in more mundane but equally consequential ways. In one Eastern Serbia interview, a young widow recounts that after giving birth, staff asked whether the father would come to register the child. After she explained that the father had died, she later discovered that the child had been registered as the child of an unknown person, requiring her to travel to another town to correct the error shortly after delivery. Institutional routines assume a two-parent model and treat paternal identity as central to legal recognition, penalizing women who fall outside this norm with additional administrative burdens at a moment of particular vulnerability.

Across these accounts, women who attempt to raise concerns or seek clarification are implicitly discouraged from doing so. In Novo Miloševo, women describe being warned not to ask too much about their own health, as such questions are read as challenges to medical authority. This silencing reinforces dependence on clinical judgment and undermines women’s autonomy in reproductive decision-making.

3.2 Disability-based discrimination and territorial exclusion

The interviews reveal discrimination rooted in institutional responses to disability that operate at both the individual and structural level. In Nikoličevo, Teodora (31), who has severe bilateral hearing loss, describes a system that formally guarantees her rights while practically denying them. She received one hearing aid through the social welfare system, but obtaining the second requires a co-payment she cannot afford:

"I got one hearing aid through social services... To get the second one I have to pay extra. The state gives something small, around 30,000 dinars, and the rest I must pay myself, around two hundred-and-something thousand for the two devices. From what are we supposed to live for a whole month if I give all our money for that?" (Teodora, 31, Nikoličevo)

The co-payment model shifts most of the cost of assistive devices onto the individual. Without the second hearing aid, Teodora cannot hear well enough to perform basic tasks, follow medical instructions or work safely. Lack of employment in turn makes the device unaffordable. The policy design locks her into a cycle in which disability is economically punitive and a recognized medical need becomes a lasting disadvantage.

In her account, disability is also produced by medical practice itself. From childhood she was treated for frequent illnesses with injections that, she later understood, damaged her hearing progressively until the loss became permanent. No explanation was provided at the time, and no pathway to remedy or compensation exists. The patient is disabled by cumulative clinical negligence that went unacknowledged.

Legal provisions require priority access for people with disabilities, but participants describe these as unenforced in practice. Teodora notes that despite her disability status she waits in standard queues, frequently unable to hear instructions or follow conversations clearly. When procedural adjustments are legally required but routinely ignored, disability rights remain symbolic rather than operative.

These inequalities intensify in rural settings where healthcare is geographically distant and transport expensive. For residents of Nikoličevo and surrounding villages, disability intersects with immobility to produce a compounded territorial disadvantage. Access to care depends less on clinical need and more on the capacity to pay for repeated long-distance travel. The broader interview material contains examples of bedridden patients who are formally entitled to care but practically required to arrange transport of their own laboratory samples to town. The health system does not adapt to disabled patients; patients are expected to adapt to the system at considerable cost to both their health and their dignity.

3.3 Age-related discrimination and the expendability of older patients

Alongside disability, the interviews reveal age-related discrimination that operates most visibly in emergency care. In Bocar, Milena (52) recounts calling emergency services for an

older neighbor and being struck by the first question she was asked before symptoms had even been described:

"You call the emergency services: 'Hello, I have a—' and they ask: 'How old is the person?' 'Eighty-five, ninety-three, for example.' And then they say: 'Ah...' What 'ah'? Who gives you the right?" (Milena, 52, Bocar)

Age functions here as a triage filter applied before clinical information is gathered. Older adults are implicitly treated as less deserving of urgent attention, their health problems as less legitimate or less worth the investment of emergency resources. This undermines the principle of healthcare as a universal entitlement and transforms age into a criterion for rationing care.

3.4 Blocked accountability and the normalization of unequal treatment

Discrimination is reproduced through institutional structures that block accountability and protect professional hierarchies as much as through individual clinical behavior. Across interviews, participants who had experienced or witnessed serious harm described the formal complaints process as effectively inaccessible. Disciplinary committees are perceived as staffed by colleagues of those being investigated, and expert witnesses as drawn from the same professional networks, creating a closed circle in which institutional self-protection takes precedence over patient redress.

In this context, inequality is sustained through governance structures as much as through individual conduct. When accountability mechanisms are structurally compromised, poor practice is normalized and patients are effectively denied the possibility of remedy. The message conveyed to affected families is that pursuing complaints is futile. Medical authority becomes non-contestable, and the burden of absorbing harm falls entirely on those least equipped to challenge it.

Taken together, these accounts show that gender discrimination and structural violence in healthcare are reproduced through interpersonal behavior, diagnostic neglect, administrative rules, communication norms and blocked accountability. The result is an environment in which women's autonomy, the rights of persons with disabilities and the dignity of older adults are routinely undermined, and in which the formal guarantees of universal and equitable care remain largely unrealized for those who need them most.

Theme 4: Intersecting Discrimination and Roma Women's Experiences in Maternal and Child Health Care

Roma women's encounters with maternal and child health services are shaped by a dense and mutually reinforcing web of explicit racism, territorial neglect, unsafe obstetric practice and structural information poverty, producing reproductive deserts that are simultaneously geographic and social.

The position of Roma women in Serbia within pregnancy, childbirth and pediatric health services cannot be understood only through what happens inside examination rooms and delivery wards. Their experiences emerge at the intersection of structural inequality, institutional discrimination, historical exclusion and culturally shaped health-related practices. Roma women's encounters with the maternal and child health system are embedded in broader social conditions: poverty, unemployment, overcrowded and inadequate housing, low or interrupted schooling, limited digital access and discrimination across other institutions such as schools, welfare offices and employment services.

4.1 Explicit and everyday discrimination: racialized encounters in health institutions

Roma women and caregivers in Roma households describe encounters with the health system that are actively humiliating rather than merely inadequate. These experiences are especially concentrated around childbirth and emergency care, where women are simultaneously physically vulnerable and socially devalued.

In Veliki Izvor, Zorka (63), Roma mother and legal guardian of her adult daughter Mila, describes how her daughter's symptoms throughout pregnancy were repeatedly dismissed as character flaws rather than investigated clinically. When Mila presented with fainting episodes and nosebleeds, she was told she was "spoiled" and "wants attention." During labor, an injection was administered without explanation, fundal pressure was applied, and the baby was separated from the mother immediately after birth without clear medical justification. The family received no explanation and no apology. As Zorka observes, the implicit message was that such outcomes are unfortunate but unsurprising when the patient is a young Roma woman from the village.

Other Roma women describe routine gynecological care in which questions about medication or procedure are met with irritation rather than explanation. In Nikolićevo, Teodora (31) recounts being given injections and tablets during pregnancy without any information about their purpose or effects:

"They gave me injections and tablets in pregnancy and did not explain anything. I told them, 'You cannot just give me something, you have to explain what it is for.' They just told me to take it and not to ask so much." (Teodora, 31, Nikoličevo)

This account illustrates how racialization operates in clinical practice: Roma women are positioned as less credible narrators of their own symptoms, less entitled to information, and more suitable for directive rather than communicative care. The instruction to "not ask so much" is not an isolated rudeness but a form of institutional silencing that denies Roma women standing as partners in their own healthcare.

As a consequence, many Roma women withdraw from preventive gynecology after traumatic or degrading encounters, returning only when absolutely necessary. This withdrawal is then read by the system as evidence of disengagement or health illiteracy, reinforcing stereotypes that obscure the institutional causes of non-attendance.

4.2 Structural discrimination and territorial neglect

Beyond explicit discrimination in clinical encounters, Roma women are affected by decisions about where services are located, which communities receive transport infrastructure and which procedures are effectively covered. In rural eastern Serbia, Roma settlements are frequently at the outermost edges of municipal territories, with no pharmacy, no functioning *ambulanta* and no reliable public transport.

In Veliki Izvor and Nikoličevo, residents describe communities that have been systematically excluded from the investments that might make healthcare accessible. For low-income Roma households dependent on irregular work and social benefits, the cost of a return taxi journey to the nearest town for a pregnancy check-up, a sick child or a psychiatric appointment can absorb a significant proportion of monthly income. When care requires repeated visits, these costs become prohibitive and families must choose between transport and food.

This pattern constitutes what the study terms territorial racialization: Roma women are simultaneously rural and Roma, living in parts of municipalities that have been consistently deprioritized in infrastructure investment. The absence of transport, pharmacies and stable primary care is not experienced as a neutral administrative gap but as evidence that their neighborhoods and bodies are accorded lesser value. As the WHO framework on the right to health makes clear, accessibility requires that services be physically reachable and financially affordable for all population groups (CESCR, 2000). For Roma women in these settlements, neither condition is reliably met.

4.3 Maternal and reproductive health: unsafe and unsupported care

Within this context of explicit and structural discrimination, Roma women's narratives of pregnancy and childbirth are marked by diagnostic uncertainty, absent information and

frequent violations of bodily integrity.

In Novo Miloševo, Vanja (33) recounts a high-risk pregnancy in which she was sent to the maternity ward six times because the due date had been miscalculated, each time being sent home again. Throughout this period she was taking medication prescribed to suppress labor that she later understood she should not have been taking at all:

"They sent me to the maternity ward six times because they did not know the exact due date. I kept drinking pills to 'keep the pregnancy closed,' and later it turned out I should have been opening, not closing. I felt like I would end up giving birth in the car." (Vanja, 33, Novo Miloševo)

Her account illustrates how diagnostic uncertainty is displaced onto the woman, who absorbs the physical, logistical and emotional costs of institutional error. The repeated journeys, the incorrect medication, the uncertainty about when and where birth would occur: each of these represents a failure of basic antenatal care that falls disproportionately on women without the resources or social capital to demand better.

The logic underlying this experience is articulated directly by Ana (45) from Novo Miloševo, whose observation about the two-tier structure of care applies with particular force to Roma women with limited income:

"Today, if you pay, you will be treated well. The others only look to write you in the computer so they have more patients in a day — that is their plus. How you leave that office, what happens to you afterwards, that does not matter." (Ana, 45, Novo Miloševo)

For Roma women, the option of private gynecology is rarely available, concentrating their exposure to the least responsive and least accountable segments of the public system.

For Zorka (63) in Veliki Izvor, the consequences of unsafe obstetric care have shaped the entire trajectory of her family's life. Her daughter Mila has lived for decades with severe hearing loss, seizures and learning difficulties that Zorka connects directly to the circumstances of her pregnancy and birth. The long chain of misrecognition that began with dismissed symptoms during pregnancy continued into Mila's childhood and adult life, with seizures and episodes of loss of consciousness attributed to emotional fragility rather than investigated neurologically:

"She has been hospitalized in psychiatry three times. And now she is worse than ever. She collapses, loses consciousness... When I took her as a girl, they said she was spoiled. When her nose bleeds, they say she picks it. 'She is just sensitive,' they say, 'it is not epilepsy'" (Zorka, 63, Veliki Izvor)

The pattern of trivialization and misattribution documented here reflects a broader clinical disposition toward Roma patients in which symptoms are interpreted through a lens of ethnic stereotyping rather than diagnostic inquiry.

4.4 Mental health: silenced, pathologized and unsupported

Mental health problems including depression, anxiety, trauma and chronic stress appear frequently in Roma women's narratives but are rarely recognized or addressed as such within the health system. The response tends toward one of two poles: either symptoms are dismissed as emotional fragility or character weakness, or they are managed through episodic psychiatric hospitalization without sustained follow-up or community-based support.

In Veliki Izvor, Ivana (31), a Roma mother of three, describes her own repeated hospitalizations without any improvement in her condition or any explanation of what is happening to her. Despite multiple admissions, there is no meaningful continuity of care, no therapeutic relationship and no support offered to her family in managing her condition between episodes.

Zorka's account of her daughter's trajectory makes the same point from a caregiver's perspective. Years of psychiatric hospitalization have not been accompanied by coherent diagnosis, accessible explanation or practical support. The cumulative effect is a family navigating severe and complex health needs largely without institutional guidance.

For Roma women themselves, the burden of discrimination, poverty and caregiving generates chronic stress that is rarely acknowledged as a health issue requiring support. Expressions of exhaustion or distress are met with instructions to endure or to prioritize their children's needs, rather than with offers of psychological help. Mental health is simultaneously over-medicalized, in the sense of a quick resort to medication or hospitalization, and under-recognized, in the absence of sustained relational and psychosocial support.

4.5 Information poverty as systemic design

Across localities, Roma women and caregivers describe a consistent pattern in which health information is withheld, communicated in inaccessible technical language or simply not offered. The result is that women make decisions, or have decisions made for them, without adequate understanding of their situation, their options or their rights.

In Novo Miloševo, Sara (25) reflects on a pregnancy in which medication was prescribed without explanation:

"I was not told why they were giving me that. They did not explain anything. You cannot just give me something; you have to explain what it is for. I learned everything from experience, not from them." (Sara, 25, Novo Miloševo)

In Nikoličevo, Teodora (31) links her hearing loss directly to a long series of injections administered in childhood without anyone explaining that these drugs carried a risk of auditory damage:

"I was often sick and they treated me only with injections. Nobody ever told me that I was not supposed to receive those injections, and my hearing kept dropping more and more... I did not know I could lose my hearing because of it." (Teodora, 31, Nikoličevo)

Her account illustrates that what is described as health illiteracy is frequently a consequence of how the system communicates rather than a property of the individual patient. Knowledge about risks, options and rights is concentrated on the professional side of the clinical encounter. Roma women, who are more likely to have interrupted schooling, limited digital access and lower baseline trust in institutions, bear the heaviest costs of this information asymmetry. Misunderstood instructions missed follow-ups and delayed responses to warning signs become structurally predictable outcomes rather than individual failures.

This dynamic is consistent with research on discrimination in maternal healthcare in Roma communities in Serbia and neighboring countries, which documents that Roma women are more likely to experience denial of care, inadequate information and disrespectful treatment, with measurable consequences for the timeliness and adequacy of antenatal and intrapartum services (Janevic et al., 2011; 2017).

Taken together, the material in this theme shows that Roma women's experiences of pregnancy, childbirth and child health in medically underserved areas are shaped by a dense web of discriminatory practices and structural disadvantages. According to our research conclusions, explicit humiliation and racist dismissal are the most visible layer. Beneath them lie territorial neglect, unsafe and unsupported obstetric care, misrecognition of mental health needs and the systematic production of information poverty. For Roma women in Nikoličevo, Veliki Izvor and Novo Miloševo, motherhood is lived as a continuous negotiation with institutions that treat them as less worthy, less credible and less entitled to care.

Conclusion

The WARM project set out to understand how women in Serbia's medical deserts access and experience reproductive and maternal care, and what it would mean to make this care genuinely available, accessible, acceptable and of good quality. By combining desk research with ethnographic fieldwork in villages around Zajecar and Kikinda, the study shows that maternal and reproductive deserts are not empty spaces without services, but landscapes where services exist mostly on paper while women encounter them as distant, fragmented, unpredictable and often unsafe.

At the level of availability and accessibility, the material documents a long and uneven erosion of rural health infrastructures. Village ambulante have been reduced to a few hours of GP coverage per week or have closed entirely, their buildings derelict and no longer in use. Gynecologists and pediatricians are concentrated in towns where they work under high caseloads and morning-only hours. Emergency services are thinly stretched, with long response times or expectations that families will transport critical patients themselves. Public transport has withered to a single school bus in many settlements and has disappeared altogether in parts of eastern Serbia since the summer of 2025. For women without cars, stable incomes or supportive kin, each pregnancy check-up or child's examination becomes a project in logistics, money and luck.

At the level of acceptability and quality, the ethnographic interviews make visible dimensions that remain absent from administrative indicators. Women describe non-consented interventions in labor, routine use of fundal pressure in stalled births, denial or non-offer of pain relief, and separation from newborns without clear medical justification. They recall humiliating comments in gynecological examinations, rough handling and being told not to ask too much about their own health. These patterns echo national and international evidence on disrespect and abuse in childbirth and fit within the broader debate on obstetric violence in Serbia (Sekulic, 2025; Bohren et al., 2015), even when women themselves do not use that term.

Structural and interpersonal problems are tightly intertwined. Shortages of staff and time, rigid administrative rules and fragmented referral pathways create pressure on providers, which is translated into rushed, brusque and sometimes degrading interactions. Documentation sometimes records examinations that were never performed, protecting institutions while undermining women's trust and their capacity to seek accountability. When families contemplate complaints after serious harm, they encounter tightly closed professional circles and are persuaded that pursuing justice is futile.

The findings also show that deserts are not experienced equally. Roma women, women with disabilities, older women and low-income households occupy the most precarious positions in these landscapes. Roma women describe racialized dismissal, being treated as less credible patients, and having their pain and mental health concerns attributed to emotional fragility rather than investigated clinically. Women with disabilities encounter co-payments that make assistive technologies unaffordable, inaccessible facilities, and the

practical impossibility of traveling to repeated specialist appointments without organized support. Older women experience implicit triage based on age, particularly in emergency care.

At the same time, the study documents fragile anchors of continuity. Individual doctors, nurses and patronage nurses are remembered as people who explain everything, visit the whole village, or stay until the last patient is seen. Women travel long distances to remain with trusted gynecologists who treat them with dignity. Family members and neighbors step in as informal drivers, translators and health navigators. These relational practices mitigate the worst effects of maternal deserts but are unevenly distributed and vulnerable to burnout, retirement and migration.

The project confirms that formal guarantees of reproductive rights and universal coverage are necessary but not sufficient. The project's findings show that maternal and reproductive deserts are produced through the intersection of workforce distribution, transport and financing, gender norms, racism, ableism and everyday practices in clinics and hospitals (see Key Definitions; Janevic et al., 2011, 2017). An effective response must therefore combine infrastructural investment with changes in communication, clinical protocols, governance and accountability. It also requires taking women's narratives seriously as evidence, and using them to refine how the state understands and monitors availability, accessibility, acceptability and quality in reproductive and maternal care.

Limitations and directions for future research

This study has several limitations that should be considered when interpreting its findings. The qualitative, purposive sample of fourteen participants is not statistically representative and was not designed to be. The findings document patterns and mechanisms rather than frequencies, and cannot be generalized to all women in the two regions or across Serbia. The reliance on narrative interviews means that the study captures women's accounts and perceptions, which may differ from clinical records or administrative data. In some cases, particularly around perinatal events that occurred years or decades earlier, accounts are subject to the effects of memory and retrospective interpretation.

The study is also bounded geographically. While the two regions — Northern Banat and the Zajecar catchment — were selected because they represent compounded disadvantage across multiple indicators, other regions of Serbia may display different configurations of desertification that this study cannot address. The absence of interviews with healthcare providers is a further limitation: their perspectives, constraints and experiences of working in underserved areas are relevant to any full account of the system and should be incorporated in future research.

The desk research phase, which informed site selection and contextual framing, remains unpublished and is therefore not independently verifiable as a cited source. Future work should seek to publish the quantitative mapping as a standalone contribution to the Serbian literature on medical deserts.

Several directions for future research follow from the findings. First, a longitudinal study tracking the same women over multiple years would allow researchers to document how reproductive and maternal deserts affect health trajectories over time, rather than capturing a single moment of experience. Second, a provider-side study exploring how physicians, nurses and patronage nurses in underserved areas understand their working conditions, constraints and relationships with patients would complement the patient-centered perspective offered here. Third, comparative work across Serbian regions beyond Zajecar and Northern Banat would help establish whether the patterns documented here are specific to these sites or constitute a more widespread feature of the Serbian health system. Fourth, the experiences of adolescent girls and young women approaching reproductive age in these communities represent a gap in the current sample that warrants dedicated investigation, given the long-term implications of early encounters with reproductive healthcare for future care-seeking behavior.

Key Recommendations

The recommendations below are organized along six strategic lines and by timeframe: short-term (within 1 to 2 years), medium-term (3 to 5 years) and long-term (beyond 5 years). A full recommendation matrix with lead responsibilities is provided in Annex 1.

1. Rebuild a predictable local maternal and child health presence

Problem addressed: Disappearing village clinics, irregular staffing, absence of gynecologists and pediatricians, and unreliable emergency response in rural and Roma-majority areas.

Action 1.1 — Define and fund a minimum rural service package

Establish a national standard that includes regular GP sessions, at least weekly nurse and patronage presence, periodic gynecological and pediatric visits, and a basic pharmacy function. Prioritize villages in Zajecar district and Northern Banat with the poorest indicators and largest Roma populations.

Lead: Ministry of Health, RFZO, district health authorities, municipal governments

Timeframe: Medium-term, with short-term pilots

Action 1.2 — Stabilize staffing and support longer rural postings

Introduce incentive packages including housing support, travel allowances, continuing education credits and financial bonuses for multi-year postings of family doctors, gynecologists, pediatricians and patronage nurses in underserved areas. Reduce reliance on retirees as primary providers through succession planning.

Lead: Ministry of Health, local governments, health centers, universities

Timeframe: Medium- to long-term

Action 1.3 — Strengthen emergency and specialist pathways

Set and monitor maximum ambulance response times, increase vehicles where needed, and establish clear protocols allowing residents to use the geographically closest hospital or specialist service regardless of administrative district borders, with cost-sharing arrangements between RFZO branches.

Lead: Ministry of Health, RFZO, emergency medical services

Timeframe: Short- to medium-term

2. Protect bodily integrity and clinical safety in pregnancy and birth

Problem addressed: Use of fundal pressure and force instead of timely caesarean section, non-consented interventions, and unnecessary separation of mothers and newborns.

Action 2.1 — Explicitly prohibit routine fundal pressure

Update national obstetric guidelines to state that the Kristeller maneuver is not acceptable as a routine practice. Require documentation and clinical justification where any fundal pressure is used and establish institutional reviews of all obstructed labors and perinatal deaths to assess the timeliness of caesarean decisions.

Lead: Ministry of Health, professional associations of gynecologists and obstetricians, hospital management

Timeframe: Short-term protocol revision, medium-term monitoring

Action 2.2 — Standardize informed consent for induction, augmentation and pain relief

Introduce short written and verbal consent procedures in accessible language, with clear explanation of indications, risks and alternatives. Ensure that all pregnant women receive basic information on pain relief options before term.

Lead: Maternity hospitals, health centers, professional chambers

Timeframe: Short-term pilots, medium-term national scale-up

Action 2.3 — Safeguard mother-baby contact

Develop joint health and social care protocols specifying that separation of mother and newborn must be clinically justified, documented and regularly reviewed. In cases involving disability or mental health concerns, require a joint case conference with the woman present before any decision on long-term separation.

Lead: Ministry of Health, Ministry of Labour and Social Affairs, maternity hospitals, centers for social work

Timeframe: Medium-term

3. Make respectful communication and accurate documentation a standard of care

Problem addressed: Humiliating language, opaque communication, medical documentation that does not reflect actual care, and absence of structured follow-up.

Action 3.1 — Adopt simple communication codes in women's health services

Co-create with staff a short concrete code of conduct on speech and behavior in maternity wards, gynecology and pediatrics, explicitly prohibiting degrading, sexualized and racist remarks. Integrate this into staff appraisals, disciplinary procedures and student training.

Lead: Hospital and health center management, professional chambers, medical and nursing faculties

Timeframe: Short-term in pilot facilities, medium-term nationwide

Action 3.2 — Align records with reality and enhance patient access to information

Require that discharge letters and examination notes reflect the actual procedures performed. Encourage staff to go through key elements of the record with patients and correct inaccuracies. Simplify procedures for patients to obtain and read their own medical records.

Lead: Ministry of Health, health centers, hospitals, RFZO

Timeframe: Short- to medium-term

Action 3.3 — Pilot recall and reminder systems for critical follow-ups

Introduce low-technology SMS and phone recall systems for abnormal Pap results, breast findings and high-risk pregnancies in Zaječar and Kikinda districts, with clear responsibilities for making and documenting contact attempts.

Lead: Health centers, regional public health institutes, RFZO

Timeframe: Short-term pilots, medium-term evaluation and scale-up

4. Address discrimination against Roma women and other marginalized groups as a systemic issue

Problem addressed: Explicit racism and humiliation documented in participants' accounts, territorial neglect of Roma-majority areas, unsafe and unsupported reproductive care, misrecognition of mental health needs and structural information poverty.

Action 4.1 — Implement anti-racism and anti-bias training linked to accreditation

Introduce mandatory recurring training on anti-discrimination, institutional racism and inclusive communication for all staff in maternal and child health services, using case material drawn from Roma women's experiences. Make participation a condition for facility accreditation and professional re-licensing.

Lead: Ministry of Health, professional chambers, medical and nursing schools

Timeframe: Medium-term, with initial modules developed in the short term

Action 4.2 — Stabilize and expand Roma Health Mediator and community health worker programs

Provide secure multi-year funding for Roma health mediators with expanded roles in reproductive, maternal and mental health support. Involve Roma women's organizations in recruitment, training and supervision.

Lead: Ministry of Health, Ministry of Labour and Social Affairs, local governments, Roma civil society

Timeframe: Short-term stabilization, medium-term expansion

Action 4.3 — Make health information understandable and co-created with Roma women

Produce plain-language visually supported materials on pregnancy, childbirth, child health, mental health and patient rights in Serbian and where relevant Romani. Use community workshops and peer education co-designed with Roma women to disseminate information and rebuild trust.

Lead: Institute of Public Health, Ministry of Health, Roma women's groups, local health centers

Timeframe: Short-term development, medium-term consolidation

5. Make disability and age-related protections effective in everyday practice

Problem addressed: Co-payments that make assistive devices unaffordable, lack of priority procedures, expectations that severely disabled patients transport themselves, and de-prioritization of older adults in emergency care.

Action 5.1 — Fully cover essential assistive technologies for low-income and rural households

Reform co-payment rules for medically necessary devices such as hearing aids so that costs are fully covered through centralized procurement and targeted exemptions for low-income and rural patients.

Lead: Ministry of Health, RFZO, Ministry of Labour and Social Affairs

Timeframe: Medium-term

Action 5.2 — Develop home and community-based services for people with severe mobility limitations

Introduce or expand home visits for sample collection, basic examinations and chronic disease management, and subsidized or organized transport for specialist appointments, starting with the most remote villages in Zajecar and Northern Banat.

Lead: Health centers, local governments, RFZO

Timeframe: Short-term pilots, medium-term extension

Action 5.3 — Enforce priority access and anti-ageism standards

Operationalize legal provisions on priority for people with disabilities and older adults in queues and scheduling. Monitor emergency response patterns for older patients and address discriminatory communication through supervision and training.

Lead: Ministry of Health, emergency services, patient-rights bodies, professional chambers

Timeframe: Short- to medium-term

6. Open up governance and accountability

Problem addressed: Closed professional circles, the perception that mistakes are covered up, and the absence of independent channels for complaints and institutional learning.

Action 6.1 — Establish independent and visible patient-rights and complaint channels

Ensure that each hospital and health center has an easily reachable patient-rights counsellor who is structurally independent from the medical hierarchy and obliged to provide feedback within a defined period. Publicly display contact information and procedures in waiting rooms and wards, including in Roma neighborhoods and in simplified language.

Lead: Ministry of Health, local health institutions, national and provincial ombuds offices

Timeframe: Short-term in pilot regions, medium-term national roll-out

Action 6.2 — Use narrative data and complaints to guide quality improvement

Collect and analyze qualitative data from complaints, patient narratives and participatory research on maternal and reproductive care, with specific attention to Roma women, women with disabilities and older adults. Use this information to design targeted quality improvement plans and periodic public reports.

Lead: Ministry of Health, public health institutes, equality bodies, academic partners

Timeframe: Medium- to long-term

These recommendations are designed as realistic entry points rather than exhaustive solutions. Implemented gradually but coherently, they would help shift the burden of adjustment away from women who currently stretch their bodies, budgets and networks to compensate for institutional gaps, and toward the institutions that bear responsibility for ensuring that reproductive and maternal care is available, accessible, acceptable and of good quality for all.

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Annex 1: Full Recommendation Matrix

The table below lists all recommendations organized by pillar, with action ID, description, lead stakeholders and timeframe. Short-term: within 1-2 years. Medium-term: 3-5 years. Long-term: beyond 5 years.

Pillar	ID	Action	Lead stakeholders	Timeframe
1. Local presence	R1.1	Define and fund a minimum rural maternal-child health package (GP, nurse/ patronage, outreach gyn/ peds, basic pharmacy)	MoH, RFZO, district health authorities, municipalities	Med (pilot short-term)
	R1.2	Incentives and succession planning to stabilize rural postings of key staff	MoH, health centers, municipalities, universities	Med-Long
	R1.3	Set maximum ambulance response times; allow use of nearest hospital across districts	MoH, RFZO, EMS, district health authorities	Short-Med
	R1.4	Targeted transport support (vouchers/organized transport) for ANC, birth, pediatric and disability care	Municipalities, social services, MoH, RFZO	Short-Med
	R1.5	Support informal community health volunteers linked to patronage nurses	Health centers, municipalities	Med
2. Bodily integrity	R2.1	Explicitly ban routine fundal pressure; document any use and review obstructed labor/ perinatal deaths	MoH, professional societies, maternity hospitals	Short (guidelines) + Med (monitor)
	R2.2	Standardized informed consent for induction, augmentation, CS and other major interventions	Maternity hospitals, professional chambers	Short-Med
	R2.3	Ensure real access to pain relief; inform women antenatally about available options	Hospitals, health centers, patronage services	Short-Med
	R2.4	Protect mother-baby contact; require joint health-social case conference before long-term separation	MoH, MoLSA, hospitals, centers for social work	Med
	R2.5	Allow and support presence of chosen support person for vulnerable women at key points	Hospitals, health centers	Short-Med

Pillar	ID	Action	Lead stakeholders	Timeframe
3. Communication & documentation	R3.1	Codes of conduct on speech/behavior in maternity, gyn and peds services	Hospital/HC management, professional chambers	Short-Med
	R3.2	Mandatory annual training on respectful communication, consent, shared decision-making	MoH, chambers, universities	Med
	R3.3	Align records with reality; explain key elements to patients; ease access to files	Hospitals, health centers, MoH, RFZO IT	Short-Med
	R3.4	Internal audits on documentation quality and concordance	Quality committees, heads of departments	Short-Med
	R3.5	Simple recall/reminder systems (SMS/phone) for critical follow-ups (Pap, breast, high-risk pregnancies)	Health centers, PH institutes, RFZO	Short (pilot)-Med
	R3.6	Use women's experiences (exit surveys, narratives) as quality indicators in planning and reporting	Hospitals/HCs, PH institutes, MoH	Med-Long
4. Roma women	R4.1	Mandatory anti-racism/anti-bias training, with real Roma cases, linked to relicensing/accreditation	MoH, chambers, schools, hospital management	Med
	R4.2	Stabilize and expand Roma Health Mediator and community health worker programs	MoH, MoLSA, municipalities, Roma CSOs	Short (stabilize)-Med (expand)
	R4.3	Co-created, plain-language (incl. Romani) information and community workshops/peer education	PH institutes, MoH, HCs, Roma women's groups	Short-Med
	R4.4	Emergency funds/vouchers for urgent obstetric and paediatric procedures; monitor informal payments	MoH, RFZO, municipalities, inspectorates	Med
	R4.5	Qualitative monitoring of discrimination and communication patterns, with guidance/alerts	Equality bodies, inspectorates, chambers	Med-Long
5. Disability & age	R5.1	Full coverage of essential assistive technologies for low-income/rural households	MoH, RFZO, MoLSA	Med
	R5.2	Home and community-based services (home sampling, basic exams, subsidized transport)	Health centers (patronage), municipalities, RFZO	Short (pilot)-Med

Pillar	ID	Action	Lead stakeholders	Timeframe
	R5.3	Enforce priority access and reasonable accommodations (queues, scheduling, communication)	Hospitals/HCs, MoH inspection	Short-Med
	R5.4	Counter ageism in emergency and routine care; review protocols, monitor patterns, train staff	MoH, EMS, PH institutes	Med
6. Governance	R6.1	Independent, visible patient-rights and complaint/counselling channels in each facility	MoH, ombuds, hospitals/HCs	Short (in pilots)-Med
	R6.2	Protect complainants from retaliation; set response deadlines; create simple appeal routes	MoH, ombuds, inspectorates, facility management	Med
	R6.3	Diversify and open expert/disciplinary bodies (independent experts, lay reps, Roma/women's orgs)	MoH, chambers, courts	Med-Long
	R6.4	Use qualitative evidence and complaints systematically in quality reports and planning cycles	MoH, PH institutes, hospitals, HCs, districts	Med-Long

Annex 2: Participant Profiles

The table below lists all fourteen participants by pseudonym, age, location and a short profile summarizing their situation and relevance to the study. All names are pseudonyms. Participants are listed in the order in which they appear in the analytical sections of the report.

Pseudonym	Age	Location	Profile
Ana	45	Novo Miloševo, Northern Banat	Mother of four and grandmother of five, living in a multi-generational rural household. Long experience with local primary care and women's health services; travels to a trusted gynecologist in a nearby town. Provides an inter-generational view of how access and quality of care have changed over time.
Sara	25	Novo Miloševo, Northern Banat	Ana's daughter, employed, mother of two small children. Went through a high-risk pregnancy requiring frequent monitoring in the regional hospital, with long travel and strong dependence on her husband for transport. Her narrative highlights bureaucratic gatekeeping, difficulties obtaining referrals and the burden of maintaining a pregnancy from a village.
Vanja	33	Novo Miloševo, Northern Banat	Unemployed at the time of interview, mother of a preterm baby born at 33 weeks in a regional hospital. Describes induction, strong uterotonic drugs, lack of information about medications, denial of epidural and verbal humiliation during labour. Core case for obstetric violence and traumatic birth in a standard public facility.
Lena	19	Novo Miloševo, Northern Banat	Young woman at the beginning of her reproductive life, not yet a mother. Speaks about school, work prospects and contacts with the health system, illustrating how young rural women form expectations and fears about future pregnancy and childbirth.
Olga	~60	Novo Miloševo, Northern Banat	Former textile-factory worker, recently retired. Experienced strong workplace-based health services in socialism and now faces gaps in pension and insurance status. Her story connects past embedded care with current experiences of being uninsured and paying out of pocket.
Marija	37	Bočar, Northern Banat	Woman living in a nearby village with limited local services, employed in a textile factory in Novo Miloševo. Describes relying on a part-time GP in the village, frequent travel for other services, and the tension between factory shifts, family care and accessing healthcare.

Pseudonym	Age	Location	Profile
Milena	52	Bočar, Northern Banat	Mother of two and grandmother, long-term worker in a textile factory. Offers a detailed comparison between earlier periods with stronger local provision and the current situation with reduced staff and fragmented services. Important for understanding changes over time in both occupational and reproductive care.
Sonja	37	Novo Miloševo, Northern Banat	Employed in a managerial role in a local firm, mother of two children, one of whom has serious health problems. Describes a mix of public and private care, heavy financial burdens and the need to navigate complex paperwork. Central for showing how even relatively stable households are pushed toward privatization of care.
Zorka	63	Veliki Izvor, Eastern Serbia	Mother of four, main caregiver and legal guardian of an adult daughter with disabilities. Her narrative spans pregnancy, a traumatic birth and long-term care for a daughter with hearing loss and seizures, plus her own chronic conditions. Key case for understanding disability, guardianship and long-term mistrust of the health system.
Ivana	31	Veliki Izvor, Eastern Serbia	Mother of three young children living in a precarious economic situation. Describes everyday juggling of childcare, work in agriculture and household, and frequent visits to doctors and emergency services. Illustrates how reproductive care is entangled with poverty, overwork and chronic illness.
Teodora	31	Nikolićevo, Eastern Serbia	Young woman with severe bilateral hearing loss, living with her husband and child in a village without its own ambulant. Her account traces how childhood treatment led to disability and how she now navigates ENT, gynecology and general care amid high costs for hearing aids, long travel and reliance on parents and partner.
Jelena	48	Klenovac, Eastern Serbia	Farmer, mother of two daughters and grandmother. Lives in a border village with no local ambulant. Describes an emergency visit where a full examination was documented but not carried out, and long-term management of chronic conditions. Her story highlights documentation, trust and care in an underserved area.
Veronika	74	Rgotina, Eastern Serbia	Retired former worker, long-standing patient of the Zaječar system and grandmother. Provides narratives about her own experiences with chronic care and the broader patterns of neglect and delayed emergency response she has witnessed over decades.
Nina	55	Brusnik, Eastern Serbia	Entrepreneur, originally from a larger city, now living in a depopulating mountain village. Mother of one child after a long period of infertility treatment. Compares different maternity hospitals and describes feeling like at the vet in a district facility versus more respectful treatment in a university clinic. Central for showing how closure of the village ambulant and poor transport shape everyday life and reproductive care.

