“And Then We Reached the Border: There were a Million Women!”

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Experiences of Roma Refugee Women from Ukraine with Sexual and Reproductive Healthcare in Hungary – in Light of the EMMA Associations Humanitarian Programme

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Abstract

For two years, EMMA Association’s (Hungary) Humanitarian Programme field workers have been helping Roma refugee women and girls from Ukraine to access services related to sexual and reproductive health (SRH). They provided complex psychosocial support to these women, also support in navigating the healthcare system and specific physical accompaniment. This publication summarizes the results of our qualitative research with twenty-one Roma refugee women. In all cases, we interviewed women who had an existing trustful relationship with EMMA field workers. Although we focused on SRH related experiences of women, to get a broader picture of their situation, we also addressed other questions relevant to refugee women, such as the circumstances of their arrival in the country, the housing difficulties, their livelihoods, their attitude towards womanhood and their plans for the future.

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“Well, at first there were talks that there was going to be a war, but we didn’t believe it, but the children were very scared from the first minute. Especially Adam, he was in shock. [...] He cried a lot, let’s go away from here, mummy, they’re going to kill us! [...] And then every night until morning we were awake, we didn’t sleep, we were very afraid. One morning we woke up and the war had started.”

– Szinti

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Foreword

The Covid-19 epidemic has resulted in severe social and economic damage worldwide, which was hardly over, when we had to face the next crisis: on 24 February 2022, Russia attacked Ukraine, escalating the Russian-Ukrainian conflict that has been going on since 2014. The outbreak of the war caused the biggest refugee and humanitarian crisis in Europe since the Yugoslav wars of the 1990s. Over the past two years, millions of people have crossed the border of Hungary and tens of thousands are still in the country, according to UN data[1].

The situation is unique in that the refugees have been mainly women and children, as shortly after the outbreak of the war, Ukrainian men aged between 18 and 60 were conscripted and were unable to leave their country. Many of the male members of families living in Transcarpathia had already been working in Hungary before the war, and they did not return after the war started, but waited until their families arrived in Hungary to be together. But we also heard of cases of men trying to cross the border illegally - some succeeded, but others were not so lucky.

> *"We wanted to come over because it was no good at home. There was this alarm, and the children were scared, and some of them were no longer sleeping, and the men were scared too, because [...] these cars used to come into the streets, and sometimes the men even had to hide."* – **Klaudia**

> *"Everyone was very scared because we were told that they were about to start shooting here. [...] I didn't want to come at all, but my dad told me to help my sister-in-law, at least to bring the two little boys over, and I would go back across the border, and the taxi would wait for me and take me back home. [...] My dad had arranged with the taxi driver to tell me that yes, this is how it's gonna happen, and when I go back across the border, the taxi would not be there. Because he was worried about me too."* – **Melinda**

> *"There were several people who tried [to cross the border], and succeeded, but there were others who tried [...] who had families, children, and they perished. So there were people who died along the way."* – **Jázmin**

1 https://data.unhcr.org/en/situations/ukraine

EMMA Association is a national women's organisation working for women's fundamental rights and social equality, with a particular focus on gender-based oppression, violence against women during childbearing and child-rearing, and sexual and reproductive health and rights (SRHR), on the individual, community, and societal level, with a particular focus on vulnerable groups of women.

Immediately after the outbreak of the war, we committed to supporting women refugees from Ukraine and have been helping them with sexual and reproductive health, with a particular focus on the needs of pregnant women. For the past two years, EMMA field workers[2] have helped women navigate the Hungarian healthcare system and provided personalised support and information on the process of antenatal care and childbirth, and on issues related to informed family planning.

In EMMA Association, we support primarily women's autonomy over their own bodies and their decisions to have children (according to relevant UN guidelines[3]), with a strong emphasis on prevention. Thus, we also provide contraceptive information and access to contraceptive devices to our beneficiaries. In cases of acute crisis, we also provided information on the options and procedures for safe abortion in Hungary, as regulated by law, and helped women to access abortion services as needed.

We have helped arrange appointments for medical visits and provided personal accompaniment to facilitate access to care and communication between health workers and women. We provided psychosocial support to beneficiaries through personal, supportive conversations. We also helped them, where appropriate, with administrative matters concerning their newborns (e.g. paternity declaration, birth registration, citizenship registration), as long as we supported them throughout their pregnancy. For legal or other issues outside our focus, we recommended our partner organisations.

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2 Field workers are our colleagues who personally visited refugee women, assisted them in psychosocial, SRHR and administrative areas and accompanied their clients to the different institutions and offices to advocate for their interests.

3 Report of the International Conference on Population and Development (Cairo, 5-13 September 1994) at https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/a_conf.171_13_rev.1.pdf

Our guiding principle in building trust and partnership, believing that everyone is the best authority on their own life. Accordingly, it is a priority to empower women, supporting their increasing autonomy and informed decision-making throughout the process of support.

The implementation of the Humanitarian Programme has also offered us a range of experiences, as we have been encountering with a particularly vulnerable group of women. Our beneficiaries are mainly women who plan to stay in Hungary for the long term, until the end of the war. These women are mostly Hungarian-speaking Roma women from Transcarpathia living in extreme poverty, who understand and speak the local language, which can be an advantage for them in this vulnerable situation. However, knowing the language is not enough to make everything seamless for them. They do not understand and therefore find it difficult to adapt to the local health and education systems, which of course operate more or less differently from those in Ukraine. This is a challenge for them, as they often come into contact with these institutions during pregnancy, childbirth or when placing their children in childcare institutions.

The structural barriers they are confronted with make their situation even more complicated: they face various forms of racism and discrimination on a daily basis, in institutional care, housing, health and the labour market. This is exacerbated by the fact that they are not seen as genuine refugees by a certain part of Hungarian society, and in some cases are blamed for the current economic problems.

Discrimination against refugee women should be examined from an intersectional approach, which assumes that the situation of certain individuals is determined by two or more attributes - such as their gender, ethnicity, socioeconomic background, etc. - which, when intertwined, cause them specific social disadvantages[4]. Women in our target group may encounter discriminatory practices from at least three aspects: as women, as Roma and as Ukrainian refugees.

4 The definition of intersectionality was made internationally famous by Kimberlé Crenshaw's 1989 article (Crenshaw 1989), but the approach is rooted in the waves of the women's liberation movement in the 1970s and 1980s in the United States as a critique of feminist and anti-racist struggles (hooks - Lutz 1993).

"It's a woman's job [...] first of all to get married, have children and so on, run a household, do what the man says, because in our community the tradition is that you have to do what the man says." – **Reni**

"They think that gypsies can't behave, they just talk dirty, they just fool around or something." – **Izabella**

"They said that it was because of us [Ukrainian refugees], that things had got worse in Hungary, that everything became more expensive and so on, that we were greedy and so on, but no, we just had to come." – **Vanda**

The focus of the research presented in this paper is the sexual and reproductive health experiences of Roma refugee women from Ukraine in Transcarpathia and the supportive psychosocial assistance provided by EMMA field workers. We opted for a qualitative method because we wanted to bring the women's experiences and stories to the forefront. In total, 21 interviews were conducted, lasting on average 1-1.5 hours. In all cases, we interviewed women who had an existing trustful relationship with at least one EMMA field worker and conducted the interviews in their own homes, providing a safe atmosphere in which more sensitive topics could be discussed.

During the semi-structured interviews, we not only focused on SRH issues, but also addressed other questions relevant to refugee women, such as the circumstances of their arrival in the country, the housing difficulties, their livelihoods, their attitude towards womanhood and their plans for the future. These topics were also worth highlighting to get a more comprehensive picture of the circumstances of refugee Roma women in Hungary. In addition to the interviews we conducted, we also relied on our own field experiences to provide a broader picture of the situation and stories of refugee Roma women.

We would like to thank all the women who, despite the difficult circumstances, were happy to share good and bad experiences, talk about easy and difficult topics, and thus contributed to the study. We hope to present their experiences in a way that is appropriate to them - their stories, their realities are the central thread of this study.

"I've never spoken to anyone like that before, except to you now, but otherwise it was good." – **Melinda**

Brief Introduction of the Interviewees

Between September and November 2023, we interviewed 21 Roma refugee women, all of whom were forced to flee their homes after the full-scale invasion of Ukraine. All were beneficiaries of EMMA Association's Humanitarian Programme and voluntarily agreed to participate in the research.

The youngest interviewee was 16 and the oldest was 46 at the time of the interview. Our interviewees include women with one child and women with six children. A significant number of them do not even have primary school education (14), many of them have literacy difficulties, and two of them said they could not read or write at all. Eight women currently live in Budapest or Pest County and thirteen of them live in rural areas. Fifteen women are Ukrainian citizens, while six are Ukrainian-Hungarian dual citizens.

Field workers from EMMA's Humanitarian Programme helped these women access services related to pregnancy (and childbirth), contraception and abortion - some in more than one case, such as maternity care followed by contraception.

For ease of reference, a table of data for women has been included. Pseudonyms have been used to protect their personal data:

Name	Age	Education level	Citizenship	Current place of residence	Number of children	Area of support provided by EMMA
Zsani	25	6 grades	Ukrainian	Budapest	1	Pregnancy
Timi	21	11 grades	Ukrainian	Rural area	1	Abortion
Szinti	30	4 grades	Ukrainian	Pest county	5	Pregnancy, contraception
Dzsenna	21	4 grades	Ukrainian	Rural area	2	Pregnancy (two children)
Kati	46	5 grades	Ukrainian-Hungarian	Rural area	5	Contraception
Eleonóra	25	6 grades	Ukrainian	Rural area	3	Pregnancy
Hajni	18	7 grades	Ukrainian	Budapest	1	Pregnancy, contraception

Name	Age	Education level	Citizenship	Current place of residence	Number of children	Area of support provided by EMMA
Miriam	32	12 grades, qualification as a cook	Ukrainian-Hungarian	Rural area	4	Abortion, contraception
Dana	30	7 grades	Ukrainian-Hungarian	Rural area	2	Contraception
Jázmin	33	5 grades	Ukrainian	Rural area	2	Contraception
Klaudia	19	9 grades (elementary school)	Ukrainian	Rural area	1	Contraception
Kriszti	30	9 grades (elementary school)	Ukrainian	Rural area	6	Pregnancy, contraception
Melinda	23	illiterate	Ukrainian	Pest county	2	Pregnancy, contraception
Vanda	19	8 grades	Ukrainian	Budapest	1	Pregnancy, contraception
Reni	23	can read and write	Ukrainian-Hungarian	Budapest	2	Pregnancy
Izabella	28	9 grades (elementary school)	Ukrainian	Budapest	2	Pregnancy, abortion
Éva	25	9 grades (elementary school)	Ukrainian-Hungarian	Budapest	2	Pregnancy
Brigi	16	9 grades (elementary school)	Ukrainian	Rural area	1	Pregnancy, contraception
Elvira	21	9 grades (elementary school)	Ukrainian	Rural area	2	Contraception
Angelika	25	illiterate	Ukrainian	Rural area	2	Contraception
Betti	27	5 grades	Ukrainian-Hungarian	Rural area	3	Contraception

Housing Inequalities and the Problems of Livelihoods from the Perspective of Roma Refugee Women

Although the focus of our services and the expertise of the organisation is sexual and reproductive health and rights, adequate housing is a basic need without which our work cannot be done effectively. On many occasions in the context of our activities, we have worked with partner organisations providing housing support and refugee shelters to help clients find accommodation. This gave us some insight into the opportunities available to Ukrainian refugees arriving in Hungary. The emerging picture is one of a system that is difficult to understand, unpredictable and overloaded, so we believe it is important to include in our research the experiences of women and their families in relation to housing.

To put into context the housing programmes and services available to Ukrainian refugees in the last two years, we need to look at the housing situation and housing policy in Hungary, as the services available to refugees may rely on existing housing infrastructure and institutions (Pósfai, Szabó 2022). This system is extremely under-resourced and does not offer a comprehensive solution for people with housing problems in Hungary, including refugees. In addition, the strengthening of the government's anti-immigration policy, which since 2015 has resulted in the gradual withdrawal and downsizing of state resources for asylum support institutions, is an important shaping factor in this regard (Pósfai, Szabó 2022).

Regarding housing solutions for refugees, Szabó and Pósfai, in their research published in 2022, just before the outbreak of the war, conclude that "there are no dedicated public housing solutions or housing policies for refugees and for people in need of international protection. Most of the housing programmes and subsidies listed among the indicators were available in Hungary only on a case-by-case or project basis, implemented by NGOs or church organisations, rather than on a permanent basis as a state housing policy programme" (Pósfai, Szabó 2022, 219).

This system was therefore not at all prepared and suitable to accommodate refugees arriving in Hungary after 24 February 2022 and to provide them with adequate housing. There had been no state housing policy for refugees and persons in need of international protection (Pósfai, Szabó 2022), and this did

not change significantly after the outbreak of the war: “the services provided by the Hungarian state are mostly limited to immediate, low-threshold crisis intervention” (Czifrusz, Pósfai 2023, 6).

The majority of the shelters available to Ukrainian refugees have been created by emptying and transforming some other social institution (homeless shelter, elderly shelter, college dormitory, childcare centre, etc.) or workers’ hostels, holiday homes and campsites, so the quality of the accommodation varies considerably. These shelters, as mentioned above, are intended for crisis intervention, and do not provide a long-term housing solution for the people living there. They do not promote integration, and the conditions and lack of space are also an obstacle to families’ independent life management (Romaversitas Foundation, 2023). In addition to the physical environment and “comfort”, there are also disparities in the services available. For example, some hostels offer free meals and social work for their residents, while others do not. The location of the shelters also varies: we have accompanied women living in facilities in the capital with good infrastructure and location, but we have also visited shelters that can only be reached by walking to the beginning of a hiking trail.

These factors were also pointed out by the women we interviewed when describing the accommodation. For example, we heard mixed views on the availability of free meals. Many did not take up the offer because cooking is seen as a responsibility of women, a manifestation of their female caring role, and preparing their own food represents a kind of independence, self-reliance, and autonomy within the institutional framework, as well as a continuity between pre- and post-war life. This is true in those cases where they had the opportunity to cook, as we also encountered many shelters with no kitchen or shared kitchens that made cooking difficult. Seen from the outside, whether or not a woman can cook in a way that is comfortable for her may not seem like the most pressing issue, but when you have to suddenly leave not only your country but your entire life, and in many cases even family members, even the smallest opportunities for connection - such as preparing “home meals” - can provide a sense of stability for refugees in an already vulnerable and constantly changing situation.

Many also highlighted overcrowding and the lack of separate toilets, bathrooms and - as mentioned above - kitchens. The use of common spaces causes discomfort and tension for families living in collective housing.

„Well, it's no good, that's the truth. I'm not used to so many people being together, and so little privacy, and no purpose in life, no job opportunities, no welfare to live on, we live on what we can. [...] Some are known to you, some are complete strangers, you've never seen them, you've never heard of them, so it's a difficult situation, especially with a small child. [...] But you can catch a disease very quickly because there are a lot of people in one place. And now it's like if you have a child or a grandchild or a relative, they put you all in one room, because there are more people coming everywhere and there's not enough space. And now you must be in the same room with them. [...] Not to mention the washing. Sometimes I have my clothes downstairs for five days, you can't even get to that machine. There are two machines, there are so many of us, fighting, arguing about the washing. The clothes are downstairs, and they can't get washed. They fight over the kitchen. There are four stoves upstairs, but only one works." – **Miriam**

Another barrier is accommodation in poorly located institutions. Several of our interviewees living in such accommodation sites cited accessibility as the biggest problem with accommodation: *"The middle of a forest. It's far away [from the city], yes, a bit. And the bus doesn't run very often. That's the one thing I don't like about it, that the city is very far away from us, and the bus service"* (Hajni). Think about how much autonomy refugees can have who live in a shelter located beyond the city limits, with difficult or no access to public transport. They are dependent on the help of others for every single administrative task or medical examination, which means a level of vulnerability that is difficult to bear even if they have a trusting relationship with the social workers and field workers who support them.

Inadequate conditions in shelters make it particularly difficult for pregnant women and women with young children. One of our interviewees who lived in a shelter outside the city, was unable to travel independently at all in the last months of her pregnancy and was driven to all the mandatory prenatal check-ups by the EMMA field worker. But we also know of a shelter from which one of our interviewees had to move because the shelter wouldn't allow newborns.

We would think that in a refugee shelter, it should be essential to have social workers to assist the people living there. This is not always the case, but where it is, the quality of care is not the same either. Over the past two years we have encounter several professionals who are working tirelessly, wholeheartedly, to make the situation of refugees easier - but we have also seen examples of the opposite. Many of our interviewees shared negative experiences about

the quantity and quality of support provided and there were also reports of condescending treatment: *"Well, there are some who do, who talk back more harshly, who don't pay so much attention to what we say, who don't care"* (Izabella). One reason for this may be, among other things, the overwork of the staff in the shelters, but this should not be an excuse for not treating people with respect.

In addition to the relationship with social workers, the institutional rules and regulations have also been restrictive for many people, preventing them from leading a free and autonomous life. In two of the shelters we visited, residents' internet use was blocked during certain time slots in order to reduce children's online activity and encourage them to play outside and do homework. However, this has infantilized adults and hindered their independence as well, and in some cases has also prevented our adult clients from communicating with us, as many do not have a phone number and can only communicate via internet platforms.

Data from the Romaversitas Foundation's 2022 research, in which the Foundation's scholars interviewed 160 Roma refugees, show that the majority of Roma families live in collective housing in Hungary, and ten refugee shelters were identified where exclusively Roma families live. Both our own field experience and our research confirm that a degree of segregation can be observed in the shelters. Given the Roma background of our beneficiaries, including our interviewees, the vast majority of them live in collective housing and in many cases the other residents are all Roma. One of our interviewees compared the accommodation where they live directly to segregated settlements in Transcarpathia, so-called Roma "camps".

> *"It's like a big village. Well, it's like a camp."* – **Eleonóra**
>
> *"Roma. Just gypsies. From all kinds of villages. From Ukraine."* – **Miriam**

Many of the women participating in the research had lived in workers' hostels for a shorter or longer period since their arrival in Hungary, as many of the male members of the families had been working here before the outbreak of the war, so the opportunity to move women and children in with their male family members seemed a natural choice. However, these shelters were not suitable for providing them with adequate housing in the long term. These families were left in a very vulnerable situation: some accommodation prices remained unchanged or even decreased after the arrival of the families, but there were also cases where the monthly fees were increased for these hostels, where conditions were already unsatisfactory, knowing that the families would

not be able to refuse in the short or long term. And although it is clear that a hostel is not the most suitable housing for a family, if you have no resources, you have no choice if you don't want to end up on the street. Sometimes, instead of understanding the woman's circumstances and difficulties, the official personnel (e.g. health visitor[5]) focused on the fact that the conditions were not suitable: *"we left because there were only workers there, families were not allowed there. But still the health visitor looked at it with a frown, not good conditions, being there with a tiny baby"* (Zsani). A general shortcoming of the domestic social welfare system is that, while it performs a sanction and control function, in many cases it fails to provide real alternatives and support. This is reflected in the situation described above. While professionals make it clear that the circumstances are not appropriate, they do not offer real help, they do not offer women a better option, and in some cases threaten to take their children away from them if they do not find better housing.

Relatively fewer of the women we interviewed live or have lived in rented accommodation in Hungary, and even fewer could afford it in the long term. Many of them also reported that they had tried to find accommodation on the rental market but had not been successful and had encountered obstacles. One obstacle was of course the high rental price:

> *"Very expensive. Very, very expensive. To pay over two hundred thousand [HUF ~ 500-530 EUR], where do you get that kind of money every month?"*
> – **Melinda**

> *"Yes, we tried [to find a rental], but it's very expensive. You need two months' deposit, one month's rent, it's very expensive. If we had to pay out as much money all at once, we wouldn't have any money to live on."*
> – **Vanda**

Another serious challenge is that the under-regulation of the private rental market in Hungary can lead to an appreciation of the "individual trust relationship", which can lead to a deterioration of the housing market situation of refugees (Pósfai, Szabó 2022). In the case of Roma families from Transcarpathia, this can be well observed in the discrimination of rent seekers of Roma origin and those with children. The structural barriers faced by Roma people from underprivileged backgrounds are also pronounced in this area, as overt discrimination against Roma people is also evident in their search for rent, with many reporting that this has hindered their access to housing.

5 The health visitor supports the health of individuals and families through regular visits (family visits) and health screenings for pregnant women and children in Hungary.

"Yes, because being Roma. It's been mentioned, by my mother or by my father, that we are gypsies, goodbye. They said, well, thank you very much. We'll call you directly, and they didn't call us back." – **Éva**

"They said I'd rather have a pet. And then they told me to sell my two children. [...] Yes, they told me to sell my two children and then buy a pet and go rent a house with it." – **Dana**

We have also seen a case where neighbours of a family living in a rented flat offered on a solidarity basis wrote a petition not to be allowed to stay there - because they are Roma, from Ukraine: *"they wrote ten letters, or rather they gathered and collected them, against us being there, to make us leave, and because of the children, because the children being noisy, the house being dirty and so on. But then the mayor came out and said that they didn't see any problem. And they said that we were messy, we were dirty, but the mayor looked around the accommodation and said that there was nothing wrong with us"* (Reni).

The relationship with the tenant in this vulnerable situation has also proved to be a determining factor in other cases. We heard from an interviewee who had been able to get independent housing with her family under a rent subsidy scheme, but the tenant of the flat had asked them to pay higher price to repay his own debts. This was noticed by the social worker of the rent subsidy scheme who was in contact with the supported family. We have also been told of cases where children were unable to go to school because the tenant did not allow them to register the rent as their place of residence.

As a result of the insecurity and scarcity of housing opportunities and the general lack of long-term housing solutions for refugees, most families have moved several times since their arrival in Hungary. Only two of our interviewees live in the same place they moved to after the outbreak of the war, the majority have lived in at least four places in the last two years.

"I thought we'd go to one place, we'd stay there, but we didn't expect this war to be this long, and they say it's going to be even longer. I don't know how to imagine this life. It's hard to wait like this." – **Kati,** who moved six times within Hungary

"I had never been outside Mukachevo (Munkács) before, not even to Kiev. For the last two years I have been slowly making my way around Europe. We have become travelling gypsies, like the old times." – **Miriam,** who has moved eight times within Hungary, has also lived in the Czech Republic and Switzerland

This uncertainty is a major obstacle to the integration of families and makes planning impossible for them. Several of them explored the range of housing options available to refugees. The lack of long-term housing has also been a frequent problem for our supporting relationships with the women. Several of the procedures we have started have stalled because the beneficiary has moved too far away from us, but there have also been cases where someone had to move, and therefore adapt to and learn to navigate a new territorial healthcare system.

A stable financial situation is a crucial factor for sexual and reproductive autonomy, just like secure housing. Our field experience and research show that traditional gender roles are strong in underprivileged Roma families in Transcarpathia, with paid work typically being performed only by men and reproductive - or invisible - work falling to women. By reproductive work we mean childbearing, child rearing and all related "management tasks" (going to childcare institutions, doctors, etc.), emotional work, domestic work such as washing, cooking, cleaning, etc., which are all perceived as a natural duty of women, i.e. "women's work", as a result of gender socialisation and social stereotypes (Csányi et al. 2018). These activities are unpaid.

The majority of the women we interviewed would find it difficult to work in addition to running a household and caring for children, but some women are explicitly not allowed to work by their husbands. In addition, the fact that most of them do not even have a primary school education and many are illiterate[6] (Romaversitas Alapítvány, 2023) also hinders their labour market participation. Many of our interviewees pointed out that there was no Hungarian-language school in the settlement where they used to live, which was a major factor in their dropping out of education. Also, early marriage[7] may play a role in girls' dropout from school.

> *"Well, yes, because the husband tells us that we can't go to work elsewhere, we have to be at home with the child, only if we really need to. And stuff like that."* – **Reni**

6 See Interviewees profile table.

7 When our interviewees talk about marriage, it does not necessarily mean that they are legally married. They simply refer to living together as such and call their partner husband.

“I couldn’t work, I wanted to work, but they wouldn’t hire me anywhere. They didn’t want to hire me, because I don’t know, I didn’t have this school certificate [qualification].” – **Zsani**

“[How long did you go to school?] Well, until I got married. [And then why did you quit?] Because in our community, once you get married, you can’t go to school.” – **Dzsenna**

Our research and field experience revealed that Roma men from Transcarpathia had typically been already present in the Hungarian labour market in recent years, further highlighting that women are generally left alone in terms of invisible work. While men work abroad, women manage the household and take care of the children alone. According to the interviews, the women’s husbands/partners were basically content with their jobs in the past - most of them working in the construction sector - and their salaries were sufficient to support their families back home in Ukraine. It should be mentioned here that most of the Roma women and their families from Transcarpathia that we supported have previously lived with a lower living standard, and the situation where one parent has to work abroad to support their family is not ideal either, but the outbreak of the war has only increased the vulnerability of these families. Employers sometimes pay workers less than they used to, make them work undeclared or withhold former extra benefits (e.g. travel allowances) because they know that *“they won’t object, employers knew they wouldn’t resist because we were in a desperate situation and so they had to [work]”* (Reni).

“The wages are not what they used to be because the bosses are taking advantage of the fact that there is this war now and they know there is no other option. If you don’t work there, or whatever, there’s nothing, you know, and we have to do the same work that we used to do, but the money used to be better than now.” – **Izabella’s husband**

“Economic Refugees”

This term is essentially incorrect. There is the concept of economic migrant, which refers to people who voluntarily leave their country of origin for reasons of economic subsistence, in the hope of better financial conditions than those available in their country of origin or habitual residence. A refugee is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion[8]. Nevertheless, the term economic refugee has been often used in Hungary to refer to people who, because they did not come to Hungary directly from war-affected areas (i.e. without having had their homes bombed), are not considered by the public to be genuine refugees. They are often seen as having left their homes not out of necessity but for “economic gain”.

Many people also consider Roma refugees from Transcarpathia to be in this category. As mentioned above, this is not a real category, but rather a way to negatively discriminate against a group of refugees “on the basis of economic logic” without being able to call them racist. The field workers working in the EMMA Association’s Humanitarian Programme encountered this discrimination daily during their field visits. These people are often asked why they left their homes if there is no war there. As if the forced separation of families, food shortages, bomb threats, unemployment and power cuts were not sufficient reasons to be entitled to refugee status in another country.

“It’s not easy for us either, so they should try it, when the electricity is on for 4 hours out of 24, and that too on and off.” – **Kriszti**

“They didn’t treat me like other refugees in the 8th district. We were rather excluded like that. So, we were looked at as gypsy, very gypsy, they looked down on us. And in many places where we went, for example, where we could get these donations, we were turned away, but the normal Ukrainians, I mean those who came from Ukraine, from up there, they were welcomed.” – **Reni**

8 Based on the 1951 Convention relating to the Status of Refugees and its 1967 Protocol by UNHCR. https://www.unhcr.org/media/1951-convention-relating-status-refugees-and-its-1967-protocol

When asked how families' livelihoods have changed since the war, virtually everyone said they have got worse. *"Well, worse. Yes, worse, because we lived better at home, and we always had money to put aside, and we could even lend money to other people, but now we don't manage to do anything"* (Timi). The reasons for this are manifold: on the one hand, illiteracy, high rates of early school drop-out and poverty, and racial discrimination in the labour market mean that Roma refugees have access only to the most uncertain, low-paid, and low-prestige jobs (Romaversitas Foundation, 2023). Several interviews also suggested that the lack of a work contract - i.e. black employment - also creates extremely insecure and difficult situations. Men usually do some form of heavy manual work, and several women reported that they had to pay for the treatment of these injuries on their own due to lack of insurance, resulting in a loss of income for families already in a poor financial situation - not to mention that in more severe cases men were then excluded from employment.

> *"The roof collapsed under him. And there he would have had to go to the doctor on his own. He had to buy everything himself, medicine, everything. And he was in bed for five months. [...] So we lived on what he had saved up, what was set aside."* – **Szinti**

In addition, many families have other responsibilities: some send money to elderly parents or other family members who stayed in Ukraine, and some have to pay off debts because their husbands were sent across the border in exchange for a large sum of money. Another woman reported that her family is in debt because her husband owes money to his employer, who also became their landlord after the war broke out. The rent for the accommodation and the arbitrarily increased "interest" are deducted from his wages.

> *"We also have to send money home to our grandparents, because if we don't, they won't be able to survive, they'll starve to death. So, we have to send money home every week."* – **Szinti**

> *"When my husband escaped across the border, others got him across, that's how he could come. And then they had to hand over a lot of money just to get him across on a boat - they paid $1,500. And then they took money from relatives so that they could pay for him to get across. And then we were in debt. So, we could pay it off recently."* – **Éva**

> *"So, what he gets [during] the payment period, his wage is withheld, for the home debt. [...] So they're just withholding the interest, plus the accommodation, because we live here. Yes, so what he takes out in*

advance, by the time the payment comes, it's not that he's going to get a new payment, a fresh payment, but it's already been taken, because he's already withdrawn [deducted by the employer]. So, every month, he gets like, I don't know, 60-70 thousand [HUF ~ 150-180 EUR]." – **Zsani**

Complex Case Management Provided by the EMMA Association

At EMMA, we work in a spirit of equality and respect for human dignity. The women we support not only receive help, but also experience a connection where they are valued, and their unique situation and needs are taken into account. Our activities are not focused solely on meeting needs, but on building a relationship where women feel truly supported and accepted, through respect for individual dignity and values.

> *"I could tell them things, I knew I wouldn't be trashed [by the field workers because of the abortion]. Because I know I'm strong, but it was hard. Everybody needs help, though."* – **Timi**

EMMA's Humanitarian Programme was prompted by the Russian invasion of Ukraine. During this programme, our field workers accompanied refugee women in and around Budapest and Eastern Hungary to help them access sexual and reproductive healthcare. Over the past two years, we have provided complex psychosocial support to our beneficiaries, in addition to orientation in the health system and actual field accompaniment.

Our aim has been to build a partnership and equal relationship with the women, to the extent appropriate to the circumstances. We did not make decisions for them, we simply provided them with as much information and as many tools as possible so they can choose the best path for them, and then supported them in doing so. In the meantime, we recognised and acknowledged the socioeconomic, ethnic and class differences between us, without judgements. We were mindful of their heightened vulnerability due to the war.

Immediately after the outbreak of the war, the only way to contact refugee women was to visit the refugee shelters in person. Here, it became immediately clear that "these shelters hosted the poorest, most vulnerable members of the Hungarian-speaking Roma community who had fled from Transcarpathia [...] - the primary target group of our Humanitarian Programme was thus the most disadvantaged group of Ukrainian refugees, Roma women expecting a child and those with young children" (Emma Association 2023, 105). During the visits, we initiated conversations with the women living there to assess their needs, the difficulties they face regarding their sexual and reproductive health, and the type of help and support they would need. To better understand the situation of women, we also held women's circles in places where this was possible.

"One time they [social workers at a rural refugee shelter] told us to go up to the reception, have a meeting and everything. And it sounded so good that we had a conversation with all the women there, and they asked everyone one after another. When it was my turn, I told them my name and she asked me how many children I had. I said two and I'm expecting one. That's very good, she says, we can help you so you can get to the doctors." – **Eleonóra**

In the meanwhile, we built professional relationships with other NGOs present in the hostels and with the social workers working there, who could later refer cases to us. We also participated in programmes for refugees and distributed posters and leaflets to spread the word about our work. We also set up a telephone helpline and later a help mail so that women could contact us in this way.

After our first trials, word of the service spread quickly. Women shared the information among themselves. During interviews, many reported that a friend, a close relative, or a distant relative had given the Association's contact details. This was good feedback for our programme from the beginning, we knew from the women's recommendations to each other that what we were doing was useful. The work we do is very confidential and requires a high level of mutual trust, so if we had not been trustworthy, we would not have been recommended. Not only was this good feedback, but women were more comfortable talking to us and trusting us if someone close to them had already had a positive experience with us.

"At first, when I hadn't met you, I just heard about you and asked Tina what you were like, how you looked and how you behaved. And then Tina said that you were very good, that you were very nice and young. [...] When you came into our house [...] and I looked at you and I knew right away that you were very good. And then you went out [...] I say, they are very good, nice, understanding, because we talked a lot right away. And I knew right away that you were very kind. [...] But even [Tina's] mother-in-law told me, even though you didn't talk to her much. She came in and [...] then she said you were very good. She's nice, she says, pure of heart." – **Szinti**

Most of our interviewees came to Hungary immediately after the outbreak of the war, so in the two years since then they have met many different humanitarian organisations, including governmental, civil, and church organisations. We also asked them how they felt about the help they received as refugees in general. They all said that they were provided with supplies

(food and a place to sleep) as soon as they crossed the border - so basic needs that needed to be met quickly were covered, but there was little information about what would happen next, or how to respond to specific situations. It should also be mentioned that some reports indicate that Roma refugees have already faced racist behaviour when crossing the border, and in some cases the staff of the aid organisations were no exception. In our multi-country study conducted with the Center for Reproductive Rights (CRR) between June 2022 and April 2023, a Roma women activist in Hungary said: "we went to the border crossing at Záhony, where we found discrimination to such an extent that if I put it on paper, even the paper wouldn't be able to take it. Roma refugees were not given food, or rather only minimal amounts, they were labelled as 'subsistence refugees'"(Center for Reproductive Rights 2023, 48).

Humanitarian aid is largely used to meet primary needs, which is understandable, but feedback from our interviewees and our own experience shows that for people in such vulnerable situations, it is very important to build long-term relationships in which trust can be established between the helper and the beneficiary. This is the kind of support we have tried to give to women. The interviewees all expressed their complete satisfaction with the work of the Association: they mostly highlighted the constant presence, supportive conversation, attention, and trust in their relationship with the field workers.

> *"Some just oh yeah, they can promise, then they leave, or they promise, and then when they come, oh, I forgot. Then I said, I can wait in vain. When she [EMMA field worker] said I'll come and I'll get it, I said, of course, everybody says that. And so far, she was the only one from such a foundation, she promised something, and she kept it. She didn't let me down."* – **Kriszti**

> *"It's a big difference compared to others, if I ask for something I get an answer or help right away. They listen to me, they talk to me, they accompany me, they give me the medicine I need, they ask me how I feel, no one else helps me like the [EMMA] Association, the social workers always say that they are busy now, they will help me later."* – **Izabella**

> *"So compared to other organisations, I think you have given me the most. No other organisation has helped me in that way. There were organizations where you could only get food, for example. We went there, they put our names down, they didn't ask us any questions, that was it. [...] The only one who helped me like that was you in the antenatal care, but you were helpful in everything. So, for me, it was incredible to get help."* – **Reni**

During the research, we also wanted to know what differences the refugee women perceived between themselves and the field workers - assuming that they must have experienced interesting differences that were unusual for them, because we grew up in a different country, in a different environment, in a different life situation, etc. Instead, all the interviewees stressed that what was unusual and unique for them was that we did not treat them differently, that we treated them as equals, that we did not differentiate between them and ourselves.

> *"I think I'm in the same place as everybody else, I didn't feel discriminated against, like being put a little bit lower down or whatever. No."* – **Timi**

> *"I don't even take that into account [whether the field worker is a Roma or not], she did not make a fuss, I offered her coffee, she drank it. She was not distant."* – **Kati**

> *"We speak differently, but we understand each other."* – **Hajni**

> *"I feel like she's just like us. She doesn't see herself as different, that she's Hungarian or whatever, and we're different or something. I don't notice. She's so compassionate."* – **Éva**

We also received feedback on what they consider to be different and better in the assistance provided by EMMA. Their responses all support the importance of women's fellowship. They believe that what makes the Association special is the empathy and care we show towards them. And the experience of womanhood, as a fundamental experience, connects the helper and the helped. Field workers not only provide professional assistance, but also build personal relationships, which provide women with significant emotional and psychological support. This is what the interviewees describe as special, as they have not received this type of support from any other helping professional.

> *"We're very glad to have you, and B. [her field worker], and any of you who work there, we're very, very glad. We can't thank her enough every single day that she come."* – **Jázmin**

> *"We can tell her everything. [...] She can give me advice on anything, and I can share anything I don't know. And then I ask her for advice on how to do it, and she explains everything in detail. [...] Well, I could stay with her all day. [...] We can talk, not just about the pregnancy, not just about the baby, but about anything."* – **Izabella**

“I’ve grown very fond of you and it’s very nice to be with you. I like talking to you because you listen to me. I don’t have anyone to talk to anymore, only when I talk to you, and I can tell you everything. [...] No one has ever done anything so good to me, not even my mum. [...] You’re like a sister to me, and you’ll always be a sister to me. My friend, my sister, and I’ll call you and write you, because I was in the mouth of death [at birth], [...] but you were by my side.” – **Szinti**

“She is a very good, blessed woman [...] And she can soothe a person’s soul, and she is a very good person.” – **Klaudia’s mother-in-law**

“It felt good not to have to go alone. Well, good, because when you go alone, you feel so lonely. When you have someone with you, it’s good because they support you.” – **Angelika**

Vanda

Our helpline for women refugees from Ukraine received a call in September 2022 from a volunteer working in a refugee shelter. She told us that they had a Roma girl, Vanda, who was underage and probably pregnant. As they could not provide her with any social services in that matter, they told Vanda which clinic to go to for a pregnancy test: she tried twice but was refused because she was underage. On the third occasion she went elsewhere and was advised to go to Heim Pál Hospital, where there is a gynaecology department specifically for minors. She went there too, alone, but it turned out that there was no gynaecology there anymore. At that point, the staff at the shelter didn’t know how to help her, so they called the EMMA humanitarian helpline.

One of the Association’s field workers went to the shelter to get to know Vanda, who was very distrustful at first, answering questions in short sentences, but over time they got to know each other better.

In Ukraine, she was raised by her father and had long since lost contact with her mother. Vanda had a friend, Ákos, who had lived and worked in Hungary before the war. Vanda was a very bright girl, she loved going to school, she even went to the special English classes that no one else attended, the others could not understand why she didn’t hang out with them in the afternoons. However, her father had to have one leg

amputated, then the other, due to an illness, and Vanda has younger siblings, so she was the one who had to drop out of school and become her father's support. When the war broke out, her father already had a new partner, so he told Vanda to leave Ukraine if she felt like it.

Vanda came over to Hungary alone. She arrived by train at Nyugati railway station, where she was very surprised to find neither professionals nor information points on where she should go as a refugee. She called Ákos to ask him what to do, and he went to pick her up and took her to the workers' hostel where he was living. This had an impact on the rest of her life. Very quickly, word got around that Vanda was sharing a room with this boy. And although there was no physical contact between them, everyone assumed and made statements to her - including her father - that they were now a couple. As a result of custom and circumstance, Vanda and Ákos officially became a couple, lived in the workers' hostel for a while, and then she became pregnant.

The first step in confirming Vanda's pregnancy and getting her to the appropriate tests was to have a designated legal guardian. A lawyer from the Patent Association helped the field worker to initiate this process. As Vanda had no other relatives or acquaintances, Ákos became her legal guardian. However, as Ákos worked during the day, he could not accompany her to the check-ups, so Ákos authorised the EMMA field worker to be her official escort and agreed in writing to the necessary check-ups being performed on Vanda.

"We spent a lot of time together, and she was totally alone, so that's why I was mothering her instead of her mother, because she had no one to turn to. She was basically sitting in the hostel all day, she had no girlfriends, she had no connections, she was waiting for Ákos to come home all day." – **A.**, field worker

After the legal guardianship was settled, a very turbulent period followed. But while the guardianship still in progress, the EMMA field worker first took Vanda to a private gynaecologist to confirm the pregnancy. There, the doctor said she needs an ultrasound scan right away, so she needs to be taken to the territorial hospital where she belongs according to her place of residence. So, they went from the private clinic to the hospital, where Vanda and the field worker met some great professionals who were very helpful and told them to come back the next day - as there was no doctor there that day - to have the ultrasound. So, they managed to get the documents which they would not have had if they had waited

for the appointment. Once the legal guardianship was completed, they could follow the normal procedure of visiting the public health visitor, going for the mandatory check-ups, and everything was fine from that point.

"It was very intense in the beginning, we spent a lot of time together, and then actually, if there was ever anything, she would come to me for help with everything. It was health issues at first, but then there was always something else." – **A.**, field worker

The EMMA field worker helped Vanda and Ákos to find a new shelter because the public health visitor was very strict about all the rules and said the shelter was not a suitable place to take a newborn baby. So, the field worker guided them to different partner organisations who could help them find accommodation. But these were for short periods, sometimes only for 30 days. At each new place of residence, it was necessary to contact the district health visitor and continue the antenatal care with this new practitioner. Vanda lived in 4 places during her pregnancy. The field worker helped her with everything she needed to do: when to go where, to book appointments, to contact health professionals, and personally accompanied her to each place.

When Vanda went into labour one night, the field worker went to the hospital with her, but ended up not being there for her delivery because Vanda's partner and the field worker were not allowed in together. A choice had to be made and Ákos thought he would like to be there, which was understandable, and they had a good experience. They had a baby girl, named Vanda after her mother. Although the birth was a good experience for Vanda overall, she had a large episiotomy that left her unable to sit properly for weeks afterwards. During her three weeks in the hospital, she did everything standing up. She breastfed standing up, she stood in the corridor waiting for Ákos to bring her a clean change of clothes and food, and Vanda stood through the visiting hours with Ákos. She could only lie down and stand.

What made Vanda's case even more difficult - and why she spent three weeks in the hospital instead of three days - was that, as a minor, she could not be the legal guardian of her own child, and her guardian could not automatically be the baby's guardian either. The EMMA field worker had known that this process could be started after the birth in order to take the child home, but she had not been aware that the guardianship proceedings would only be started once the baby's

birth certificate was available. Vanda was one of the first to give birth during the EMMA Humanitarian Programme - we hadn't figured out the whole system yet, so it wasn't yet clear for us to get her a family status certificate beforehand, which is required because she is not married. This document is needed to process the newborn's paperwork. So, after the birth, another ordeal began. The field worker spoke to the hospital health visitor and the patient's representative, about how to resolve the situation, because it was obviously not in the hospital's interest to keep a healthy mother and her newborn baby in unnecessary care. However, the registrar refused to issue the birth certificate until the family status certificate in Hungarian was available.

To do this, the field worker first picked Vanda up from the hospital and took her to the Ukrainian Embassy, where they received the status certificate in Ukrainian – despite their request, it was not issued in English, which would have been accepted by the registrar. The Ukrainian certificate therefore had to be taken to the National Office for Translation and Translation Validation (OFFI) for a certified translation, a process that took about two weeks. At this point, the field worker asked the registrar to start the process of registering the baby, as the certificate was already available and being translated. This would have allowed Vanda to go home as she was really struggling in the hospital, but the registrar was not bothered. So, it was necessary to wait until the translation was completed. When the translation was finally ready, Vanda was again picked up by the field worker, taken from the hospital to the registrar, and the birth certificate was issued. The field worker took Vanda back to the hospital, and the birth certificate was handed over to the child welfare office, where the preparation of the documents took another one or two days. Then Vanda was taken again from the hospital to the child welfare office, received the paperwork, which was brought back to the hospital and the baby could be finally taken home.

During the same period, another minor accompanied by the field worker also gave birth in another hospital, and after three days she was granted a birth certificate and was allowed to go home because the registrar in that district recognised the difficulty and importance of the situation. Vanda spent three weeks in hospital solely because of bureaucratic formalities.

Vanda's postpartum period was also accompanied by the field worker. Vanda discussed all childcare related issues and everything else with her. The field worker also helped her to get contraceptives. They

developed a very close relationship during the 10 months they spent together, and the process ended in August 2023, which Vanda described in her interview as follows:

“She always accompanied me. She brought me what I needed, and we got to like each other, I love A., I love her very much. [...] She helped me with everything. I am very happy to have met her. [...] When I was scared, she told me not to be scared, that everything would be fine, she kept me strong and everything. [...] She always talked to me, she made me fully understand everything. She was good to me emotionally too, she supported me in every way she could. Yes, I loved A. very much because she was like a mother to me. She spoke to me the same way as if she had been my mother. She explained everything, everything that you should and shouldn’t do during pregnancy. I love A. very much, I am proud of her. [...] She always came to see me [at the hospital] when she could, when she had time. When I felt bad, I would cry on her shoulders. She reassured me, told me that I would be okay. She always kept my spirits up, that Vanda we will get through this, that everything would be fine, that she would try her best to get everything ready as soon as possible. And she always called me on the phone or texted me if she couldn’t come to see me.”

Roma Refugee Women's Experiences of Sexual and Reproductive Healthcare in Hungary

Public spending on healthcare in Hungary is significantly below the EU average and the health system remains too hospital-focused, with insufficient attention paid to primary care and prevention. Various reforms and investments are needed to reduce the performance deficit compared to the rest of the EU[9]. The impact of this is felt not only in the poor infrastructural conditions but also in the quality of medical care for patients. An overburdened, underfunded healthcare system leads to overworked and burnt-out healthcare staff, contributing to emigration as well as to career abandonment and shifting to the private health system[10]. Of course, this makes the system even more overburdened, with less and less attention being paid to what healthcare should really be about: the patient. This in turn can be an ideal breeding ground for mistreatment - so those who can afford it move to the private health system. On the one hand, this creates the illusion of buying better care, since the private sector will not necessarily treat people better, and on the other hand, it makes the upper strata of society completely unaware of the dysfunctions of the public health system, which may lead to their passivity about the problem.

For the more vulnerable, underprivileged groups in society, access to paid, possibly higher quality care is not an option at all (Szigeti 2023), so they fully exposed to the weaknesses of the public health system. Moreover, the distribution and access to health services also shows inequalities in terms of geographical location within the country, between rural and (metropolitan) urban areas. This has consequences such as higher rates of inadequate information, long waiting lists, misdiagnosis and, in the worst cases, humili-

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9 State of Health in the EU. Hungary Country Health Profile 2019. OECD, European Observatory on Health Systems and Policies. https://read.oecd-ilibrary.org/social-issues-migration-health/hungary-country-health-profile-2019_4b7ba48c-en#page1

10 Physicians and Physiotherapists in the EU: how many? Eurostat, 2023. https://ec.europa.eu/eurostat/en/web/products-eurostat-news/w/ddn-20230818-1

ating and disrespectful treatment, racism, sexism, obstetric violence[11] are also regularly found in less developed locations.

The Association has helped the Roma refugee beneficiaries to access sexual and reproductive health services. Our support was needed mainly because it is not reasonable to expect foreigners to understand the regulations in the country, especially if they are in some cases so complicated that they are not even straightforward for local women. Access to antenatal care, childbirth, abortion, and contraception[12] consists of many steps and is sometimes unnecessarily complicated.

Prenatal care is regulated by the Health Ministry Decree 26/2014 (IV. 8.)[13] which precisely defines the course of prenatal services. The first step is to have the pregnancy confirmed by a gynaecologist, who issues a certificate of pregnancy, which must be presented to the district health visitor, who issues a prenatal care record book. Then women have to go to their general practitioner, who writes a referral for the first laboratory test. According to the Decree, the pregnant woman must see the gynaecologist and the health visitor at least once every trimester, after the first check-ups. However, in general, even in the case of healthy pregnancies, even more frequent visits to the gynaecologist are expected, at least once a month. And if a complication develops, women need to see a doctor even more often.[14]

In Hungary, access to abortion is regulated by Act LXXIX of 1992 on the Protection of Fetal Life[15]. Once a gynaecologist has confirmed the pregnancy, and the woman decides not to keep the fetus, the next step is

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11 "Obstetric violence is defined as any intervention or treatment that occurs to a woman or her newborn baby without her consent (often without her knowledge) or against her will, at any stage of obstetric care, including during the antenatal period, the delivery process, and the puerperium. Violation of human dignity, patient rights, and the right to self-determination of the woman giving birth from a position of authority." (Garai 2016, 1).

12 Women were accompanied to a provider in a private facility for contraceptive care.

13 Text of the Decree: https://net.jogtar.hu/jogszabaly?docid=a1400026.emm

14 More Detailed Information on Prenatal Care in Hungary (in Hungarian): https://gyerekszoba.hu/terhesseg/a-terhesgondozas-menete-vizsgalatok-es-tennivalok/

15 Text of the Regulation: https://net.jogtar.hu/jogszabaly?docid=99200079.tv

to contact the family protection service and book an appointment for the first consultation. The aim of the first consultation is to encourage the woman to keep the fetus, so the family support worker will inform the woman about the childcare benefits available to her. A report of this session is provided, then after a three-day waiting period, the woman will need to take this report to the next family support consultation, where she will be given specific information on the abortion procedure and then fill in a formal application form. Afterwards, - or in the meantime - the necessary preparations for the operation must be made: laboratory tests, consultation with an anaesthesiologist and an appointment with the hospital.[16]

"In both cases, I thought about the fact that we are in a difficult situation, moving from one place to another. [...] We're not at home in our own house, just sitting at home and taking care of the baby, we're here and we've got a lot to go through." – **Timi,** *who had two abortions in Hungary*

As the functioning of the healthcare system, regulations and legislation differ from country to country, refugees need to be fully informed - but information is not properly accessible in Hungary. Women from Ukraine, even if they were competent in their own care, have not been aware of how the system works (for example, what compulsory examinations[17] they have to undergo during pregnancy in Hungary), therefore could not meet the "requirements". And if they do not attend the check-ups, they are held accountable afterwards. One of the things we have done through our Humanitarian Programme is to help our beneficiaries to be aware of the rules, obligations, and rights in Hungary.

"When EMMA helps, it's easier, but when I do it myself, it's more difficult, because I don't understand the rules here." – **Brigi**

16 More Information on Abortion Care: https://www.patent.org.hu/dokumentumok/abortion-pocket-guide.pdf

17 In fact, these tests are non-mandatory because all examinations can be refused, but there are or can be consequences if a woman does not go. The report of the ombudsman on antenatal care, which states that the tests are non-mandatory: https://www.ajbh.hu/web/ajbh-en/-/the-commissioner-for-fundamental-rights-stands-up-for-clarifying-the-legal-obligations-and-legal-consequences-related-to-prenatal-care

In many cases, unfortunately, medical staff are not familiar with the rights of refugee or dual citizen women (having fled to Hungary because of the war), as they have probably not been properly informed either.

We also helped our beneficiaries to reduce the costs associated with sexual and reproductive health. We provided them with donations tailored to their personal needs: pregnant women received a birthing kit, mothers and newborns were supplied with the necessary hygiene products, medicines, vitamins, as well as the payment of any medical expenses related to pregnancy and contraception. The women interviewed in our research could not have afforded these expenses, especially major costs such as a contraceptive IUD, or could only pay for them with extreme difficulty.

Access to women's healthcare should not be dependent on economic factors, as violations of sexual and reproductive health rights are violations of human rights[18]. Nevertheless, social and economic inequalities cause a number of complex problems related to health and well-being: "low education, poor quality housing, low income, livelihood problems, exclusion and marginalisation due to discrimination, and limited access to education, employment and housing are all factors that hinder and limit access to and use of sexual and reproductive healthcare as well as basic healthcare services and medicines" (Ignácz 2023, 13).

Women all over the world can face prejudice and stigma for their reproductive choices. If they have "too many" children, they are irresponsible; if they have an abortion, they are heartless; if they need a morning-after pill[19], they are "easy". In addition, women bear the bulk of the responsibility for contraception, not only mentally but also financially, especially as they suffer the consequences of inadequate contraception. In Hungary, there are currently no benefits or state subsidies for contraceptives - and the same applies to hygiene products related to menstrual health. These problems also

18 European Parliament: Report on the Situation of SRHR in the EU, in the Frame of Women's Health. https://www.europarl.europa.eu/doceo/document/A-9-2021-0169_EN.html

19 Our helpline for refugee women has received several calls about the process of obtaining morning-after pills. Currently, Hungary and Poland are the only countries in the European Union where this contraceptive is only available by prescription, which makes it very difficult for refugee women to access it. Read more about the conditions of the morning-after pill in Hungary (in Hungarian): https://merce.hu/2024/01/18/nehany-ora-alatt-tobb-mint-tizezren-irtak-ala-a-veny-nelkuli-esemeny-utani-tablettat-kovetelo-peticiot/ The petition of Patent Association to make the morning-after pill available without a prescription (in Hungarian): https://patent.org.hu/item/esemeny-utani-tablettat-recept-nelkul

affect more vulnerable groups of women, such as the Roma refugee women we support, who in many cases are subject to the whims and limitations of the healthcare system and/or men.

In our research, we asked women what it means to them to be a woman. All the responses to this question reflected the embedded conformity to traditional gender roles in women's everyday lives. Not all of them think that this separation of roles is necessarily bad, but none of them reported that being a woman is simple, easy, and carefree.

> *"There is a lot to carry with children. With everything. You have to suffer more than a man. Men just work, make money, and that's it, they're done. That's life. I have to give birth, raise children, do the laundry, cook, clean, I take care of the troubles between the kids. I get a lot of stress and it's hard. Not just with the kids, with my husband. [...] If you have so many children, it is all the same. I feel sorry for all of them."* – **Szinti**

> *"Anyway, being a woman is very difficult, because a man can't be compared to a woman in any way, because what a woman has to go through, what I've gone through with my first and second [children]. [...] A woman has to pay more attention to everything than a man. I mean in the house, in the household and all that. [...] It's more difficult for a woman, she has to take care of a lot more things. Because a man just works, he's fine. But a woman has to take care of her baby in the house, sort out the paperwork, medical stuff, everything. [...] It's very tiring for a woman."* – **Éva**

> *"What I want, I can get, and what I can't, I know I can't. So, what I want, I can get as a woman. What I can't have, I won't have. Or what I can't allow myself, or what Sanyi [her husband] won't allow me."* – **Timi**

> *"If somebody doesn't like something about the way you and your partner are together, they immediately say that you're sleeping with him and they call you names, and let me just not say what they call you, and if you're not married it's a shame. [...] And for them [men] it is a great pride."* – **Melinda**

> *"Well, the way I see it, for example, my role is to do the housework and the cooking and raising the children. That's what I do, but it's not the case that if I have a job, for example, I also go to work, but for me it's like, now I'm raising the kids, cooking, and doing the housework, that's my job."* – **Dana**

“Because being a mother is a difficult job. And then all the chores, I don’t think men can experience that, and they can’t play a role in it.”
– **Izabella**

It is relevant for our research to look at the operation of the Hungarian healthcare system from the perspective of Roma women[20]. The Hungarian healthcare system is paternalistic in its attitudes, and institutionalised racism is strongly present. The concept of institutionalised racism implies that racism permeates the whole structure of society in a systematic way. This includes patterns of discrimination based on ethnicity that are embedded in existing social institutions beyond interpersonal relations. For example, the institutions of the police, healthcare and education systems operate in ways that favour certain groups and exclude others (Giddens 2008, 224).

Roma women in the Hungarian society face a wide range of structural problems in all areas of their lives. Care related to their sexual and reproductive health and rights is no exception. Due to their marginalised and disadvantaged position, they are “under-informed, often afraid of unfamiliar social institutions and bureaucratic processes, uncertain because they cannot find their way around the building, they do not know the system, they do not know what will happen at the examination, who to ask for help” (Ignácz 2023, 14). The condescending treatment of staff only adds to the fear and uncertainty about the health system. Kitti Balogh-Szabó (2023), in her case study of a content analysis of Roma women’s birth stories, concludes that the main cause of fear is lack of information. This could be overcome by appropriate sex education programmes and adequate information provided by the health system and its practitioners. What can also be emphasized is the presence and support of a trusted person: “the vulnerability, the discriminatory behaviour of hospital staff, the lack of information, in all cases, is more positive if the mother can count on the active presence of a supportive person” (Balogh-Szabó 2023, 99).

20 According to official statistics, Hungary has one of the largest Roma populations in the European Union. There are around 700,000 Roma living in Hungary (around 7% of the total population) who still face poverty, exclusion, and discrimination in basic areas of life such as housing, education, employment, and health. These challenges particularly affect Roma women, who often face multiple forms of discrimination based on their gender, ethnicity, and social status. They face discrimination in accessing SRH care and family planning services. Pregnant, Roma women have limited access to maternity care services, and once they do access services, they often suffer from discriminatory treatment, verbal harassment, segregation, and obstetric violence.

From February 2022, Ukrainian refugees, including our beneficiaries, the Hungarian-speaking Roma women from Transcarpathia, arrived in the already run-down healthcare system, which is more or less described here.

Refugees' access to information about their own situation was very difficult in the context we studied. Although official authorities, humanitarian organisations and NGOs still update regulations and information on refugees on their websites in several languages, produce leaflets, posters, information booklets and have set up information points (most of which are now closed), refugees are not informed where to find them and how to use them. And even if they do receive the necessary information, it is not at all certain that they have the right equipment (smartphone, internet, laptop) to access the sites. Another problem is that the wording of these regulations is complicated and requires complex text comprehension - i.e. it is not easily understood - and although the women we interviewed all speak Hungarian, due to their different dialects and the segregated school system in Ukraine[21] they have difficulty understanding – if they understand at all - the regulations that apply to them, therefore the information does not ultimately reach them. EMMA Association bridged this information gap through its activities in the Humanitarian Programme.

In addition to the lack of information, we should also mention that "the way healthcare staff treats them is often humiliating, characterised by hierarchical as well as an official approach" (Emma Association 2023, 107). Women are often turned away on the grounds that they are not eligible for care. However, this is not true, but instead results from staff not being properly informed or sometimes making arbitrary decisions on their own authority. Kriszti, for example, tried to get into antenatal examinations before contacting EMMA, about which she said: *"I was told to go to examination room one. I waited in line, 'til three in the afternoon, from eight in the morning. The doctor came out and told me to come back tomorrow because he had to go to the maternity ward. I went back the next day, stood in the queue, he said I shouldn't go here, I had to go to the second room, and that's how it was. After that, I didn't even go, I didn't feel like it"*. If health workers are nonetheless willing to provide them with care, women can expect comments that contain explicit or implicit racial discrimination. Kriszti told us about her birth that: *"well, when I went to give birth to my baby here, the lady downstairs who examined me didn't even examine me properly. But she*

21 The interviewees told such and similar stories about the state of education in Transcarpathia: *"That's how we were in school. Often, they didn't teach us, they made us sit in the back, not in the front, and the Hungarian children were made to sit in the front, they were given attention. If they didn't understand something, they went to them and explained, but not to us"* (Melinda).

talked to me like I was a dog, and then she took me to the maternity ward and said: 'I brought a refugee, she's going to have her kid and we're going to pay for bringing it up'. And then she said, 'Don't take care of her, take care of the other lady, she can wait,' she said to the doctor. [...] Well, she examined me downstairs to see how many centimeters I was open, but she didn't even examine me properly. She acted like I was some kind of leper".

Of course, the presence of EMMA field workers does not make everything perfect: institutionalised racism, sexism and prejudice against refugees do not disappear, as the deficiencies of the system are more deeply rooted, but the companion can mitigate the effect of mistreatment, and her presence can create a safe atmosphere for the woman, who is more relaxed and confident during the examinations.

> *"It's very useful [the work of the Association], because there are many women in a lot of pain, who didn't realise at home that they had to go there [to a gynaecologist]. I, if it hadn't been for B., if it hadn't been for the Association, I might not have changed [the IUD], I wouldn't have gone to the doctor. So, more and more people, everybody is getting it done."* – **Jázmin**
>
> *"Before EMMA I was turned away from the hospital, they were not authorized, they said. With EMMA, I received the care and they talked to me properly."* – **Timi**
>
> *"When they hear that you come from a foundation, they have a different attitude. If somebody is there next to you, somebody is helping you, then they treat you differently. [...] Whenever we went, they welcomed us, they spoke nicely, normally. And here I didn't even get into the examination room when I went alone."* – **Kriszti**

At the outbreak of the war, it was possible to cross the border into Hungary temporarily without proper documents, considering the state of emergency. Thus, many refugees arrived not only without passports, but often without identity cards, with only a birth certificate. However, these documents would have been needed later in the course of administrative procedures (e.g. obtaining documents for the baby after birth, access to healthcare for dual citizens). The replacement of these documents in Hungary is difficult and complicated. A passport can be requested at the Embassy, but it takes six months to get one, as it is sent for processing to Ukraine, and an identity card can only be issued in Ukraine (whereas in Poland, for example, both can be done locally and with faster turnaround times). For this reason, refugees are

often advised to go home to their war-torn country and get their documents done there, since it is faster. A further difficulty in dealing with cases is that the Ukrainian Embassy in Budapest usually administers cases in Ukrainian, and only in rare cases it is possible to communicate with staff in English or Hungarian. Hungarian-speaking refugees from Transcarpathia, on the other hand, speak no or minimal Ukrainian, making it almost impossible for them to manage their affairs without external assistance.

During the course of our work, we encountered mostly two groups of refugees from Ukraine: Ukrainian citizens having applied for temporary protection status and dual Hungarian-Ukrainian citizens who, although they had arrived because of the war, were not eligible for temporary protection status (and the card proving this status).

Although the rights associated with temporary protection status (TPS)[22] are relatively clear and, after some initial difficulties, health workers are already aware of the rights of refugees, there are still some disruptions. The validity date printed on the protection status card is 4 March 2023. As the war has not ended by this date, the validity of the card has been extended by a decision of the European Union[23]. Nevertheless, the card still shows the original expiry date, which regularly causes problems in the health sector. Often, people are refused care because the card has "expired", which indicates that practitioners are not aware of its validity. The same is true for temporary protection (TP) holders who are not properly informed. So, although they are entitled to access healthcare, they do not make use of it because they are not aware that they could. And if they do try to see a doctor, they may be refused treatment by the care system because they are not sufficiently informed either.

So, while the rights of TP holders have become relatively well understood, dual citizens still face obstacles in accessing healthcare. This group of refugees is not entitled to a TP card certifying their refugee status, but if they arrived in Hungary after 24 February 2022, they are entitled to the same rights as those with TPS. However, it is much more difficult for them to prove this in the absence of the card.

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22 Information to the Refugges Arriving from Ukraine: http://www.bmbah.hu/index.php?option=com_k2&view=item&layout=item&id=1753&Itemid=2124&lang=en#

23 More information on the Extension of the Temporary Protection Card: https://helsinki.hu/en/temporary-protection-card-extended-until-2025/

Dual citizens can prove their entitlement to the benefits with a stamp in their Ukrainian passport showing they crossed the border after the outbreak of the war. However, in many cases they do not have this proof since:

- many refugees do not have passports, which they did not need as it was possible to cross the border without proper documents at the start of the war,
- they crossed the Hungarian border with their Hungarian passports, so there is no stamp in their Ukrainian passports confirming the date of crossing the border,
- they crossed the border when there was no border control at all (this was often the case at the outbreak of the war),
- they entered the country unofficially.

In such situations, the unofficial recommendation from the immigration department is to return to Ukraine, then come back with the appropriate documents and obtain a stamp confirming the border crossing – as if we were not talking about a country at war. Of the 21 women we interviewed, six were dual citizens, and the associated problems affected them too.

> *"Well, before EMMA, I didn't really visit any gynaecologists, because it was only in emergency, I didn't get any medical care, so after that I didn't go anywhere. Well, there's nothing else to tell you about it. So, I went home [to Ukraine], so I got care at home with any other problems I had, after that I didn't approach anybody in Hungary. It's only you guys now who help, during the pregnancy."* – **Reni,** Ukrainian-Hungarian citizen

Although the legislation states that a formal written declaration about having crossed the border after 24 February 2022 is a proof making them eligible for healthcare and other benefits, this is not yet implemented in practice. Most dual citizens, health workers and social workers are not aware of this option. As a result, dual citizens are easily excluded from the care to which they are entitled. These problems were reported by all dual nationality interviewees.

> *"When I was living in Pest, I was upset because I was a dual citizen, and they wouldn't give me any help because I didn't have a refugee card and they said you don't qualify because you're a dual citizen. [...] And we were living in a shelter there, and they wouldn't register my residence, I couldn't even get my basic allowance because I didn't have an address. I couldn't get anything for the children because I didn't have an address. Everywhere I went they just wanted my address. Now I have some*

support, that too requires an address in Pest. [...] I talked to them, and they told me to at least bring a document that I was temporarily living in Pest, but I couldn't because there was no such document." – **Kati,** Ukrainian-Hungarian citizen

Healthcare facilities frequently require an address card and/or social security card in the case of dual citizens, as they would for Hungarians. However, a social security card can only be issued to a dual citizen if they have a registered job and/or address. Our interviewees did not have a registered job, and once someone has a registered Hungarian address card, they will indeed not be entitled to the benefits available for TP holders.

In our fieldwork experience, the most difficult situations have been dual citizenship. However, in our work we have also tried to be an advocacy role model for women and fight for their legitimate benefits without compromising their rights and interests.

Éva

Éva, a dual Ukrainian-Hungarian citizen, met an EMMA field worker at the immigration department in June 2023, where she helped her partner to fill in the necessary documents for asylum status. Éva was about 19 weeks pregnant at the time, and the field worker immediately offered to help her, which she gladly accepted. She had not attended any prenatal check-ups until that time, as they had only arrived in Hungary in May. The field worker took Éva to a private clinic for the first time to check the health of the fetus. The doctor found everything in good order, so they then went to the competent public health centre, where the doctor on duty told Éva that she was not entitled to free healthcare because she did not have a valid social security card.

The field worker informed the doctor that Act LXXIX of 1992 on the Protection of Fetal Life states that all Hungarian citizens residing in Hungary are entitled to free prenatal care. The doctor then sent them out of the examination room and told the field worker to recite the laws in the hallway, adding that she would only attend Éva if she received written instructions from the Office of the Director-General. The field worker managed to talk to several members of the health centre management, but the doctor still insisted that Éva must have a valid social security card.

After the unsuccessful attempt to ensure prenatal care for Éva, the field worker wrote a letter of complaint to the Office of the Director-General and to the patient representative of the health centre. The patient's representative confirmed that Éva was entitled to the care and informed the field worker about further possibilities to take legal action. In parallel, a reply was received from the Director-General stating that Éva was not entitled to the benefit.

The field worker then contacted the National Public Health Centre to review Éva's case. In her letter, she detailed that a fundamental problem experienced by our Association is that pregnant Ukrainian refugee women with dual Ukrainian-Hungarian citizenship, especially after establishing a Hungarian address, are not receiving healthcare without a valid insurance status and a social security card. We have therefore regularly experienced health workers refusing to provide care to expectant mothers.

We found a practitioner who performed the ultrasound scan without valid insurance. During one of the scans a spot was found on the heart of the fetus, and Éva was referred for a fetal echocardiogram. The field worker contacted the relevant cardiology institute and was told that no further examination was necessary based on the findings.

"Yes, it was very calcified [the placenta], and they knew that very well at the time. Because we already did the first ultrasound, it was already seen there. I was at five months I think, or four?! Something like that. They told me at that time that it was already very calcified and that's why they wrote that it was a high-risk pregnancy. And they saw this paper. And still, they didn't want to examine me." – **Éva**

The local health visitor contacted Éva in time, but found out relatively late, at the end of August, that she had had a thrombosis after her first birth. On learning this, the field worker tried again to get Éva to the territorial health centre, but they still refused to provide care. So, Éva was taken to a private facility to have a blood test for thrombosis factors.

Meanwhile, the field worker started the process for Éva to obtain a certificate of eligibility for health services on the basis of social necessity. This took a month and a half to be issued, but it was the best option for her to access healthcare free of charge.

At the end of August, Eva called the field worker because something was leaking between her legs, and after a brief discussion they decided that it might be amniotic fluid, so they had to go to the hospital. At that time, the results of the thrombosis panel had not yet come in, but on that very day they received the official certificate that allowed Éva to access healthcare on the basis of social necessity. Éva's baby daughter was born the next day, at 33 weeks of pregnancy, by caesarean section, placed in an incubator, but fortunately she was born healthy and strong.

After Éva's birth, we received a letter from the Government Office stating that the information in our complaint had been investigated and was substantiated, and that the Public Health Department would take the necessary steps within its competence.

"We were delighted to receive the letter from the government office, but by then Éva's premature baby was born. Éva was classified as a high-risk pregnant woman, yet the health centre refused to provide her with free care." – **N.,** field worker

The field worker has been in constant contact with Éva for 10 months, helping her in any way she could. This is how Éva described their supportive relationship in her interview:

"Well, she helped me a lot, a lot of things, even as a friend, so a lot of things that I need, she just helps me, she's there, she takes the time, everything. Very much everything. Like a mother. She was like a mother to me, still is like a mother. She cares about everything, making sure that everything is right. She's very, very nice, very normal. Very much. Everything, the way she stands there, the way she talks, everything. Understanding, very much. […] At first, I didn't think that she would be so supportive of me, and that she would be there for me. And all the time, she came to see me in the hospital, she was there, everything."

Afterword

At the end of the interviews, we asked each woman how they see their future, what their plans and dreams are. Almost all of them answered with the hope that the war would end, and they could return home. Others said that what mattered to them was that the family could be together, and that if they had that, they would be happy wherever they were. Roma women who have fled from Transcarpathia want the same basic things as everyone else. Security, love, stability.

> *"I wouldn't mind if tomorrow they told us to go home. It's good here in Hungary, I'm not saying it's not good, because we are grateful to be supported, but home is the best place to be."* – **Kati**

> *"We feel much better at home. Cooking, family visiting, offering food to everyone, eating, laughing, sitting down, having a coffee, or just sitting and talking, is better than being here with strangers."* – **Izabella**

> *"I wish I had a house of my own, where it was only us. This is my biggest dream."* – **Timi**

For the past two years, the field workers of the EMMA Association's Humanitarian Programme have been dedicated to ensuring that women - and their families - have an easier time while staying in Hungary. During the Programme, not only have the women learned from us, we have also learned a lot from them: about humility, patience, fear, hope, joy and sorrow. They let us into their homes and shared their most personal stories and experiences of womanhood with us, some of which we were personally part of. Our lives have been shaped and touched as much by this kind of complex case management work as the lives of the women we have supported. We hope that, even if only a little, we have made a real positive difference in their lives, and that they will look back on our time together with the warm feelings expressed in the interviews.

> *"I don't tell anyone about my pain, only if I meet you and you listen to me, you give me advice, it feels so good and it will be bad when you won't come here anymore. Because I've never had a relationship like this with anyone but you. And I'm really sorry that this is coming to an end."* – **Szinti**

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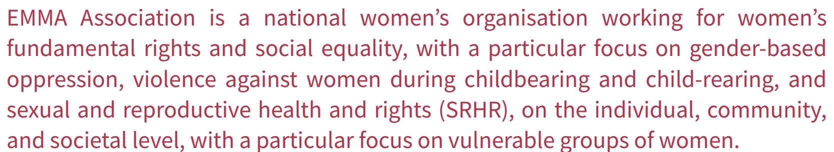

EMMA Association is a national women's organisation working for women's fundamental rights and social equality, with a particular focus on gender-based oppression, violence against women during childbearing and child-rearing, and sexual and reproductive health and rights (SRHR), on the individual, community, and societal level, with a particular focus on vulnerable groups of women.

The focus of our qualitative research presented in this paper is on the experiences of Roma refugee women from Transcarpathia in Ukraine, with a special focus on their experiences related to SRHR, and the complex, tailored psychosocial support provided by field workers of the Association's Humanitarian Programme.

"The children were trampled on as if they were on the ground. It was very difficult. We ran with the children, they were crying. We all were scared and were crying." – **Szinti**

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