



# **QUALITATIVE STUDY ON FACTORS INFLUENCING CHILD VACCINATION IN ROMA COMMUNITIES IN REPUBLIC OF MOLDOVA**

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MINISTERUL SĂNĂTĂȚII  
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## QUALITATIVE STUDY

# ON FACTORS INFLUENCING CHILD VACCINATION IN ROMA COMMUNITIES

IN REPUBLIC OF MOLDOVA

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### RESPONSIBLE OFFICER

**Stratulat Cristina**

Social and Behaviour Change Officer

### CONTACT

[cstratulat@unicef.org](mailto:cstratulat@unicef.org)

### ORGANIZATION

UNICEF Moldova Country Office

Nr. 131, str. 31 August 1989, MD-2012, Chișinău, Moldova

### CONTACT

[chisinau@unicef.org](mailto:chisinau@unicef.org)

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## ABBREVIATIONS

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**BCG** – Bacillus Calmette–Guérin (vaccine against tuberculosis)

**COM-B** – Capability, Opportunity, Motivation – Behaviour

**CRI** – Childhood Routine Immunization

**HCW`s** – Healthcare Workers

**MoH** – Ministry of Health

**PMF** – Performance Monitoring Framework

**RI** – Routine Immunization

**SBC** – Social and Behaviour Change

**UNICEF** – United Nations Children’s Fund

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## EXECUTIVE SUMMARY

12

Focus Group Discussions

30

In-Depth Interviews

2

Pilot Communities  
(Sorooca & Otaci)

Roma communities in Moldova experience significantly lower childhood immunization rates compared to the general population. While official data identifies approximately 10,000 Roma individuals, unofficial estimates range up to 250,000. This study, conducted by UNICEF Moldova between May 2025 and February 2026 in Otaci and Sorooca, aimed to identify barriers to immunization uptake and co-design culturally appropriate interventions with Roma communities.

The research employed a behavioural science-driven approach guided by the COM-B model, integrating human-centered design and participatory methods. Data collection included 12 focus group discussions and 30 in-depth interviews with mothers, caregivers, healthcare providers, social workers, teachers, and community leaders. Two participatory workshops ensured community ownership of findings and solutions.

Six interconnected barriers emerged:

- ▶ **Trust and treatment:** past discrimination experiences erode trust, driving families to seek care abroad;
- ▶ **Information gaps:** misinformation spreads rapidly through social networks while healthcare workers provide minimal explanations;
- ▶ **Discrimination:** disrespectful interactions strain provider-patient relationships, though some providers demonstrate exceptional care;
- ▶ **Family dynamics:** vaccination decisions require approval from husbands and mothers-in-law, not just mothers;
- ▶ **Practical barriers:** informal payments, migration patterns, and transportation challenges impede access;
- ▶ **Underutilized mediators:** Roma mediators possess community trust but lack training and healthcare system integration, resulting in sub-optimal health care service uptake by the community.

Despite these barriers, communities possess important assets including strong community identity, respected leaders, dedicated gathering spaces, and communication networks.

Three co-designed interventions address these barriers as an integrated package, sequenced to first repair relationships, then build knowledge and family-level support, and then finally to establish continuity. These will be operationalized through a set of behaviourally informed implementation packages developed as part of this consultancy:

1. **Friendly Clinic Hours:** Dedicated weekly sessions at both Sorooca and Otaci clinics providing respectful, unhurried care in child-friendly environments. Sessions are discussion-first and vaccination-optional, with structured mini-talks on topics identified during fieldwork (side effects, vaccine quality, patient rights, triage), Roma mediator presence at every session, and optional involvement of religious and community leaders. The goal is to change the felt experience of care before emphasising vaccination uptake.
2. **Family Health Circles:** Monthly community gatherings in trusted spaces, co-facilitated by Roma mediators and "positive deviant" mother leaders who model pro-vaccination behaviour. Sessions address vaccine myths, build accurate knowledge, and explicitly engage the family decision-makers identified in the research (husbands and mothers-in-law) to shift the socio-normative environment toward supporting timely childhood immunization.
3. **Mediator Support and Integration:** Structured training, a shared vaccination calendar and reminder system, and a formal joint action plan and standard operating procedures formalising mediator–clinic collaboration. Trained mediators proactively follow up with families on upcoming and missed vaccine appointments, reducing the discontinuity caused by migration and lost records. A monthly podcast in Romani, reinforces key messages from Clinic Hours and Family Health Circles and extends reach through existing community communication networks.

Together, these interventions are designed to improve trust in local health services and increase timely immunization uptake among Roma children in Sorooca and Otaci, thus addressing not only vaccine hesitancy but the relational and structural conditions that make hesitancy persist.

## 1. INTRODUCTION

Providing vaccination for every child everywhere and ensuring that caregivers decide to timely vaccinate their children is Ministry of Health and UNICEF's fundamental goal and requires a thorough understanding of the barriers that may hinder reaching these goals in specific populations. In Moldova, efforts have been made to sustain vaccine supply, improve healthcare workers' (HCWs) capacities and promote demand for getting all children vaccinated. Nevertheless, disproportionate differences exist among children in marginalized communities, such as the Roma, compared with those from the general population.

Research has been conducted to understand the environmental (e.g. system-level characteristics, infrastructures and resources), social (e.g. norms and peer groups) and individual influences (e.g. fear of side effects and trust in vaccines) affecting the uptake of childhood routine immunization (CRI). However, barriers identified in the general population may be markedly different for those children and caregivers who are from marginalized populations.

In Moldova, Roma communities have shown lower readiness to vaccinate their children, which is hypothesized to be related to myriad factors, including multi-level systemic challenges as well as sub-cultural specificities. Members of these communities do not normally engage with formalized systems, including due to discrimination, and their children are often not sent to kindergartens and attend schools. All of these affect effective immunization service delivery. To gain meaningful insights about barriers that originate from within or outside these communities, researchers must gain trust of members of Roma communities not only by speaking their language but also by understanding their cultural nuances.

To strengthen the appropriateness of nationwide strategies to promote demand for CRI, and improve national capacities to efficiently identify and tackle barriers across the social spectrum, it is imperative that the realities of specific sub-populations are also thoroughly understood. There is a need for a comprehensive approach that can guide countries to follow best-practice processes and evidence-informed approaches to engage with marginalized populations and relevant stakeholders, use suitable assessment tools for identifying barriers and develop evidence-based solutions to improve nationwide CRI. Through this study, UNICEF Moldova aims to support the development of a comprehensive user guide and toolkit that could provide a basis for the country to carry out a systematic analysis of their national situation regarding the uptake of CRI from the perspectives of relevant marginalized populations, and develop solutions to tackle the identified priority barriers.

## Background

The Roma population in Moldova represents a significant minority group, though exact population figures remain contested. Official census data from 2024 indicates approximately 10,000 Roma individuals (0.4% of the population), while unofficial estimates by Roma leaders suggest numbers between 20,000 to 250,000 (National Bureau of Statistics of the Republic of Moldova, 2025). This discrepancy reflects challenges in data collection, including reluctance to self-identify as Roma due to stigmatization and lack of documentation among some community members (United Nations Human Rights Council, 2017), a challenge that is similarly echoed in the literature.<sup>1</sup>

In Moldova, census data indicates that Roma communities are predominantly concentrated in urban areas and on the outskirts of urban centres, with significant populations in the regions of Soroca, Otaci, Schinoasa, and Chetrosu. These settlements often exist in geographical isolation from mainstream healthcare facilities, with limited infrastructure and public transportation connections. In Soroca and Otaci - the two focus communities for the present study - however, linkages with health facilities and ability to access services were not a notable barrier according to key stakeholders, nor was a hesitation to self-identify as Roma.

Data from studies on the Roma across Europe point to several critical, multilayered challenges affecting childhood immunization coverage in these communities<sup>2</sup>. Many study authors emphasize the importance of considering social determinants and an intersectional approach in understanding low immunization. Structural barriers include geographical isolation, lack of transportation, and at times, inadequate healthcare infrastructure in certain Roma settlements. Administrative barriers encompass documentation requirements, complex registration procedures, and insufficient cultural competency among healthcare providers. Sociocultural barriers manifest through deep-rooted distrust of healthcare institutions, language barriers in certain communities (although this issue was notably absent according to interviews with key stakeholders in Otaci and Soroca), and traditional beliefs about health and illness. Economic barriers include both direct costs (transportation, unofficial payments) and opportunity costs (lost work time, childcare arrangements). The mobile nature of some Roma communities, combined with seasonal migration patterns for economic opportunities, further disrupts vaccination continuity. Additionally, many Roma children may lack official documentation, including birth registration or vaccination cards, creating barriers to accessing healthcare services. Among those who have initiated vaccination, delayed schedules and incomplete series are common, complicated by inconsistent record-keeping, lost vaccination cards, or vaccination records obtained in other countries<sup>3</sup>. However, precise numbers of under immunized Roma children seem to be absent or inconsistent based on evidence from formal literature and existing data.

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<sup>1</sup> Orton & Anderson de Cuevas, 2019; Parekh & Rose, 2011.

<sup>2</sup> Cronin & Ibrahim, 2022; Mytton et al., 2017; Parekh & Rose, 2011.

The stakeholder ecosystem surrounding Roma childhood immunization includes multiple actors. Primary healthcare providers, particularly family doctors and community nurses, serve as front-line immunization providers. Roma community mediators, where present, play a crucial bridging role between healthcare services and communities. Local public health authorities oversee immunization programs, while social services departments often interact with Roma families regarding documentation and social support. Local Roma organizations and community leaders serve as crucial intermediaries, though their capacity and coverage vary significantly across regions. Religious leaders and traditional healers also influence health-seeking behaviours within communities.

Documented successful interventions include the implementation of Roma health mediator programs, mobile vaccination units serving isolated communities, and integrated service delivery combining immunization with other social services. Community engagement approaches utilizing Roma leaders and peer educators have shown promise in building trust and improving vaccination uptake. However, evidence gaps remain regarding the long-term sustainability of these interventions and their effectiveness in different local contexts within Moldova. Most successful programs have required sustained funding and institutional support, which has not always been consistently available.

It is important to note significant gaps in available data regarding Roma immunization coverage and health outcomes in Moldova. Current evidence relies heavily on small-scale studies and qualitative assessments, with limited systematic data collection at the national level. This constrains our ability to fully quantify the scope of immunization challenges and evaluate intervention effectiveness.

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<sup>3</sup> Orton & Anderson de Cuevas, 2019.

## 2. RESEARCH PURPOSE, OBJECTIVES, KEY QUESTIONS AND DELIVERABLES

### Purpose:

Immunization uptake among marginalized communities is often hindered by a complex interplay of social, cultural, and systemic barriers. The Roma communities in Otaci and Soroca, Moldova, face multiple challenges that have limited the success of traditional public health campaigns and awareness-raising efforts. To improve immunization rates effectively, interventions must go beyond generic outreach and instead be tailored to the specific needs, lived experiences, and cultural contexts of these communities.

This project aims to identify the key barriers and enablers of immunization uptake among the Roma in these two communities and develop culturally appropriate interventions that address these challenges. A critical component of this effort is ensuring that the Roma communities are actively involved in identifying barriers, co-designing solutions, and implementing interventions that are both sustainable and impactful.

### Objectives:

1. Engage Roma communities in the identification of key barriers to immunization and the design of localized, culturally appropriate solutions.
2. Develop interventions that successfully improve immunization rates by considering behavioural science, human-centred design, implementation research, and anti-stigma theories.
3. Ensure that community members (such as Roma mediators, village elders, and healthcare providers) take ownership of the activities, so they become integrated into daily life.

**Table 1** below provides a bird's eye view of the key questions that will guide the research for each objective.

TABLE 1: OBJECTIVES AND KEY QUESTIONS AND KEY QUESTIONS	
SPECIFIC OBJECTIVE	KEY QUESTIONS
To engage Roma communities in the identification of key barriers to immunization and the design of localized, culturally appropriate solutions.	<p><i>Overarching question: What are the most effective, collaborative, and respectful ways of uncovering the lived experiences and perspectives of the Roma communities, while engaging them as agents and co-participants in the process?</i></p> <ul style="list-style-type: none"> <li>▶ <b>What</b> are the key social, cultural, and structural barriers preventing Roma communities in Otaci and Soroca from accessing immunization services?</li> <li>▶ What factors or experiences encourage immunization uptake among Roma families, and how can these be amplified?</li> </ul>

SPECIFIC OBJECTIVE	KEY QUESTIONS
	<ul style="list-style-type: none"> <li>▶ How do historical and systemic challenges (e.g., stigma, discrimination, mistrust in healthcare, mobility) impact immunization behaviours in these communities?</li> </ul>
<p><b>To develop interventions that successfully improve immunization rates by considering behavioural science, human-centred design, implementation research, and anti-stigma theories.</b></p>	<p><i>Overarching question: What are the most feasible, acceptable, culturally appropriate, and sustainable solutions that can be employed by UNICEF to increase immunization in this population?</i></p> <ul style="list-style-type: none"> <li>▶ How can interventions be tailored to align with the Roma community's cultural beliefs, traditions, and lived experiences?</li> <li>▶ What behavioural science and human-centred design approaches can be applied to ensure that interventions are effective, acceptable, and sustainable?</li> <li>▶ How can interventions be co-designed with Roma community members to ensure true ownership?</li> <li>▶ What existing real-world evidence and administrative data can be utilized to track and evaluate the intervention's impact?</li> </ul>
<p><b>To ensure that community members (such as Roma mediators, village elders, and healthcare providers) take ownership of the activities so they become integrated into daily life.</b></p>	<p><i>Overarching question: How can behavioural science be leveraged to ensure community members and key stakeholders take ownership of immunization efforts to ensure long-term integration and sustainability within daily life?</i></p> <ul style="list-style-type: none"> <li>▶ Who are the most trusted and influential figures within Roma communities, and how can they be engaged as champions for immunization?</li> <li>▶ What mechanisms can be put in place to ensure that community-led solutions are integrated into everyday life and supported by local stakeholders?</li> <li>▶ How can the impact of interventions be measured and iterated upon to ensure continuous improvement, adaptation, and possible scale-up?</li> </ul>

### 3. METHODOLOGY

This study employed a qualitative, behavioural science-driven approach that integrated human-centred design and implementation research to develop localized interventions for improving immunization uptake among Roma communities. The methodology was designed to address the complex interplay of social, cultural, and systemic factors influencing vaccination decisions within this priority population.

The approach examined both individual-level behavioural drivers and system-level factors affecting immunization uptake. Drawing from desk reviews, focus groups, interviews, and participatory workshops, the study identified barriers and enablers shaping immunization behaviours, including structural issues (healthcare access, policy gaps) and social determinants (institutional trust, cultural norms, stigma). The COM-B model (Capability, Opportunity, Motivation - Behaviour) served as a key framework for diagnosing behavioural drivers, complemented by established immunization frameworks and anti-stigma theories to ensure a comprehensive understanding of vaccination behaviours within this context.



Figure 1: The COM-B Model (Michie, S., Atkins, L., & West, R. (2014). *The behaviour change wheel. A guide to designing interventions*, 1, 1003-1010)

The study was conducted in six phases between May 2025 and February 2026. Two participatory workshops with health authorities, Roma community leaders, and partner organizations served as critical touchpoints throughout the process. The first workshop in August 2025 engaged stakeholders in collaborative data collection activities, while the second workshop in October-November 2025 focused on validation and solution development, where participants collaboratively refined findings and co-created intervention prototypes. These workshops ensured community ownership and that proposed interventions were feasible, acceptable, and adaptable in real-world settings. Solutions were examined for feasibility and acceptability, and refined based on empirical insights and community feedback, ensuring interventions were evidence-based, culturally appropriate, and sustainable within the targeted communities.

## Data Collection

Data collection took place in August 2025 across two sites in Moldova: Soroca and Otaci. The study employed a mixed-methods qualitative approach consisting of 12 focus group discussions (6-10 participants per group) and 30 in-depth interviews, equally distributed between the two locations.

Participants were purposively selected to capture diverse perspectives on immunization uptake within Roma communities. The sample included mothers and caregivers (including vaccine-hesitant mothers), frontline service providers (health workers, social workers, Roma mediators, and teachers), as well as key community influencers (religious leaders and grandparents). This multi-stakeholder approach ensured comprehensive insights into the behavioural, social, and systemic factors influencing vaccination decisions, while capturing both demand-side barriers from families and supply-side challenges from service providers working directly with Roma communities.

## 4. FINDINGS

01	<b>Trust &amp; Treatment</b>	Past discrimination experiences erode trust, driving families to seek care abroad
02	<b>Information Gaps</b>	Misinformation spreads rapidly through social networks while healthcare workers provide minimal explanations
03	<b>Discrimination</b>	Disrespectful interactions strain provider-patient relationships, though some providers demonstrate exceptional care
04	<b>Family Dynamics</b>	Vaccination decisions require approval from husbands and mothers-in-law, not just mothers
05	<b>Practical Barriers</b>	Informal payments, migration patterns, and transportation challenges impede access
06	<b>Underutilized Mediators</b>	Roma mediators possess community trust but lack training and healthcare system integration

### Trust and Treatment

Trust in healthcare among Roma families is profoundly shaped by past experiences of discrimination and disrespectful treatment, creating significant barriers to vaccination uptake. While families generally trust medicine and value healthcare, they perceive medical services in Chisinau or abroad as superior to local care. This perception drives some families to avoid local healthcare providers entirely or seek vaccination services outside Moldova, where they believe they will receive better treatment.

The relationship between healthcare workers and Roma families is characterized by mutual mistrust and exhaustion that undermines effective care. Families described experiences of being spoken to disrespectfully. As one religious leader noted, "We believe doctors are from God, but sometimes they talk to us like we're not people." Healthcare workers themselves acknowledged the strain, with one noting that "sometimes doctors need calming drops." This tension is cyclical: negative past experiences erode trust, leading to avoidance or defensive behaviors that further strain provider-patient relationships on both sides.

Families who vaccinate abroad cite concrete differences in service quality that extend beyond clinical care. They report receiving respectful treatment, access to interpreters, and detailed information about vaccine benefits and potential side effects, elements that are often missing in local encounters. As one mother explained, "In Germany they showed pictures and told me what every vaccine was for." These positive experiences contrast sharply with local interactions and reinforce

perceptions of quality differences. Additionally, some families pursue vaccination abroad to access social benefits available to vaccinated children. Religious groups do not appear to broadly oppose vaccination or healthcare recommendations, though attitudes may vary across different religious communities.

*"We believe doctors are from God, but sometimes they talk to us like we're not people."*

— Religious leader

### Information and Misinformation

Myths and misinformation about vaccines circulate widely within Roma communities, amplified by a lack of accessible, accurate information tailored to their needs. Misinformation spreads rapidly through informal communication networks (referred to as "Roma mail") with social media stories, often from Russian sources, gaining particular traction. In both Soroca and Otaci, respondents referenced a specific case of a child allegedly paralyzed after vaccination, illustrating how single narratives can become widely accepted as fact within the community. As one mother explained, "They said a child couldn't walk after a vaccine; it goes around fast."

The information gap is exacerbated by limited communication from healthcare workers, who provide minimal information about vaccine benefits and potential side effects during clinical encounters. When families seek reassurance or explanations, they often receive dismissive responses rather than substantive information. "The nurse only said, 'Don't be afraid.' That's not an answer," one mother recalled. As a result, fear spreads faster than facts, leaving families to fill knowledge gaps with stories from their social networks rather than evidence-based information. As one father noted, "If someone posts on Facebook, everyone believes it. But the doctor never comes to explain."

Beliefs about vaccine quality further complicate uptake. Some families believe vaccines produced or administered in other countries are superior to those available locally, reinforcing patterns of seeking care abroad. Interestingly, many Roma families accept the BCG vaccine because it is administered at the maternity ward shortly after birth, but refuse subsequent vaccines, suggesting that timing, context, and setting influence acceptance as much as vaccine-specific concerns.

Roma mediators, who could serve as trusted bridges between healthcare systems and communities, have limited training on vaccines and available medical services for vulnerable groups, yet are widely regarded as opinion leaders. This represents a missed opportunity to counter misinformation with culturally appropriate, accurate information delivered by trusted community members.

*"If someone posts on Facebook, everyone believes it. But the doctor never comes to*

*explain."*

— Father, Otaci

## Respectful Care and Discrimination

Interactions between medical staff and Roma families are often strained, with communication gaps and perceived disrespect undermining trust and vaccine uptake. Families reported that some healthcare workers use derogatory expressions, shout at patients, or expect informal payments for services. Beyond overt hostility, many described more subtle forms of discrimination. "They don't always insult you, but you feel it, you're not welcome," one mother explained. Others are described as brusque, failing to answer questions or issuing ultimatums rather than engaging in dialogue. As one caregiver recalled, "One nurse told me, 'If you don't vaccinate, don't come back.' So I didn't." These negative interactions reinforce perceptions of discrimination and contribute to families' reluctance to engage with local healthcare services.

However, experiences are not uniformly negative. Some healthcare providers are described as exceptionally kind and caring; demonstrating that respectful, patient-centered care is possible within the current system. As one father noted, "When they smile and explain, we listen. We're not against vaccines, just against being treated badly." This variation highlights that discrimination is not universal but rather reflects individual provider attitudes and systemic gaps in cultural competency training.

Healthcare workers also described challenges from their perspective. They noted that some Roma patients, particularly younger, non-elderly, or non-religious individuals, may be noisy, fail to respect appointment times, or display behaviors that disrupt clinic operations. One family doctor observed, "Some Roma come loud because they expect to be ignored. That's how the shouting starts." These tensions reflect a breakdown in mutual respect and understanding on both sides of the provider-patient relationship, creating a cycle where negative expectations reinforce negative behaviors.

A critical missed opportunity lies in the disconnect between medical staff and Roma mediators. Healthcare providers generally do not contact or liaise with mediators, despite their potential to bridge cultural and communication gaps. This lack of collaboration means that mediators - who could facilitate respectful interactions and address misunderstandings - remain underutilized in the healthcare system.

*"One nurse told me, 'If you don't vaccinate, don't come back.' So, I didn't."*

— Caregiver, Soroca

## Family and Social Influence

Health decisions within Roma families are rarely made individually; traditional family hierarchies heavily influence whether children are vaccinated. While primary responsibility for vaccination decisions typically falls to mothers, these decisions must be discussed with and approved by husbands and, in some households, extended family members including the husband's parents. As one mother explained, "I wanted to vaccinate, but my husband said to wait until his mother agreed." This multi-layered decision-making process means that even when a mother is convinced of vaccination's importance, she may face resistance from other family members whose concerns or beliefs carry significant weight.

The mother-in-law plays a particularly significant role in vaccination decisions and broader child-rearing matters. Mothers often seek advice from their mothers-in-law, whose past experiences, beliefs, and attitudes toward healthcare can strongly influence whether vaccines are accepted or refused. As one grandmother noted with confidence, "If the grandmother says yes, everyone listens." This intergenerational dynamic means that addressing vaccine hesitancy requires engaging not only parents but also grandparents who hold authority within family structures.

Despite these hierarchical dynamics, some mothers do vaccinate against the wishes of other family members, demonstrating individual agencies even within traditional structures. However, such decisions may come at social cost or require navigating family tensions. The husband's role is also notable: husbands usually accompany their wives to medical appointments when vaccinating children, reflecting both family involvement in health decisions and cultural expectations around women's mobility and interactions with healthcare providers. As one mother shared, "My husband came with me to see how it goes- then he told others it was fine," illustrating how husbands can serve as validators whose approval influences broader family acceptance.

This finding underscores that effective immunization interventions must recognize and work within existing family structures rather than addressing mothers in isolation. Strategies that engage multiple family decision-makers including fathers, grandparents, and extended family, are more likely to succeed than those targeting mothers alone.

*"I wanted to vaccinate, but my husband said to wait until his mother agreed."*

— Mother, Otaci

## Practical Barriers

Even when motivated to vaccinate, Roma families face significant practical barriers that impede access to immunization services. Financial obstacles include informal costs and expectations of

payment that families often do not understand. Some caregivers reported being expected to give gifts to healthcare workers or being asked to pay for services that should be free, creating confusion and resentment. As one mother stated, "If you don't pay, they don't look at you the same way." These informal payments represent a substantial burden for economically marginalized families and reinforce perceptions that healthcare is not truly accessible to them.

Migration patterns create substantial logistical challenges that disrupt vaccination continuity. As families move for work or other reasons, caregivers change, contact information becomes outdated, and documentation is lost or transferred incompletely. Healthcare providers struggle to maintain contact: "No phone messages, calling; we cannot, because they have a thousand and one phone numbers," one family doctor explained. One health worker noted the documentation challenge simply: "The grandmother doesn't know where the vaccine card is." When providers lack patient medical history or vaccination records, families become anxious about safety. As one caregiver asked at the validation workshop, "The doctor doesn't know anything about my child because I was in Germany; how will he vaccinate without an examination or blood test first to make sure everything is ok?" This fear of harm due to incomplete information leads some families to avoid vaccination altogether.

Geographic and transportation barriers further limit access. Health facilities may be located at considerable distance from Roma settlements, and families reported experiencing discrimination when attempting to use public transportation. "The driver didn't stop because we're Roma," one father recounted. These mobility constraints are particularly challenging for mothers who typically manage children's healthcare but may have limited independent access to transportation, especially when husbands are away from work.

Together, these practical barriers mean that even families who trust vaccines and want to vaccinate their children may be unable to do so. Addressing immunization uptake requires not only changing attitudes but also removing the structural obstacles that prevent motivated families from accessing services.

*"The grandmother doesn't know where the vaccine card is."*

— Health worker, Soroca

## Mediators and Local Trust Brokers Underutilized

Roma mediators serve as crucial bridges between Roma families and health services, yet their potential remains significantly underutilized within the healthcare system. Mediators possess cultural knowledge and community trust that could facilitate vaccine uptake, but systemic barriers prevent

them from fulfilling this role effectively. As one mediator explained, "We understand Roma better; they listen to us." Despite this advantage, many healthcare workers view mediators as outsiders or question their qualifications, limiting collaboration and integration into clinical workflows.

Both Roma mediators and local community leaders face limited access to healthcare providers and report feeling unwelcome in healthcare settings. This disconnect means that the very individuals who could facilitate communication, address misunderstandings, and build trust between providers and families are excluded from meaningful engagement. Medical staff generally do not proactively contact or liaise with mediators, missing opportunities to leverage their cultural expertise and community relationships.

Families often trust mediators more than healthcare staff, viewing them as advocates who understand their experiences and can navigate complex healthcare systems on their behalf. Healthcare providers have observed the positive impact mediators can have on clinical interactions. As one nurse noted, "If the mediator comes with them, they behave differently" suggesting that mediator presence can reduce tension and improve communication. However, mediators themselves lack adequate training on vaccines and available medical services for vulnerable groups, limiting their ability to provide accurate health information and counter misinformation effectively.

This finding highlights a critical missed opportunity: Roma mediators represent a ready resource for improving vaccine uptake, yet systemic underinvestment in their training, integration, and collaboration with healthcare providers prevents them from realizing their full potential as trusted intermediaries.

*"If the mediator comes with them, they behave differently."*

— Nurse, Otaci

## Enablers and Assets

Despite significant barriers, Roma communities possess important assets and enablers that can be leveraged to improve vaccination uptake. Strong community identity and cohesion provide a foundation for collective action, with dedicated spaces for community gatherings - such as the Happy House in Otaci - offering venues for health education and dialogue. These spaces represent trusted environments where families feel comfortable discussing health concerns and receiving information.

Dedicated community leaders and Roma mediators command respect within their communities and can serve as powerful advocates for vaccination. Similarly, a small but influential group of pro-vaccination parents and newly religious individuals express willingness to "do the right thing,"

including vaccinating their children. These early adopters can model positive behaviors and influence broader community attitudes through their social networks and personal testimonies.

Within the healthcare system, some providers demonstrate exceptional dedication to serving Roma families. In Sorooca, a proactive medical director has taken initiative to improve access and quality of care. Individual healthcare workers who approach Roma patients with respect and cultural sensitivity show that positive provider-patient relationships are achievable. Additionally, teachers, social workers, and other service providers express willingness to support Roma families, representing potential partners in comprehensive vaccination efforts.

The same communication channels that spread misinformation can also disseminate accurate health information. "Roma mail" networks and widespread social media use - particularly TikTok and Instagram - offer opportunities to reach families rapidly with culturally appropriate messaging. Returnees who had positive vaccination and healthcare experiences abroad serve as credible messengers who can counter negative narratives about local services based on their comparative experiences.

Finally, community and religious leaders demonstrate openness to hosting health discussions and collaborating with the healthcare system, providing crucial entry points for engagement and trust-building initiatives.

**Table 2** maps the key barriers to immunization in Roma communities to the components of the COM-B behavioural model: capability, opportunity, and motivation.

TABLE 2: BARRIERS MAPPED TO COM-B COMPONENTS			
Barrier Category	Capability	Opportunity	Motivation
Low trust & poor treatment		✓	✓
(Mis)information & limited knowledge	✓		
Discrimination		✓	✓
Family influence		✓	
Practical challenges		✓	
Underutilized mediators	✓	✓	

✓ = Primary COM-B component affected by this barrier



## 5. PROPOSED SOLUTIONS

The three proposed solutions below address identified barriers as an integrated package, sequenced to first repair relationships, then build knowledge and family-level support, and then finally to establish continuity of care.

### SOLUTION 1 ROMA-FRIENDLY CLINIC HOURS

**OBJECTIVE:** *To provide dedicated time and space for Roma families to receive care from trusted providers in a calm, child-friendly environment, gradually building trust and improving relationships between families and healthcare workers.*

- ▶ Regular sessions where Roma families know they will be well-treated, able to ask questions, and receive respectful care
- ▶ Initial sessions focus on open conversations with the option to vaccinate; later sessions increasingly emphasize vaccination as trust develops
- ▶ Services include childhood immunization, well-baby checkups, and open discussion sessions addressing specific community concerns
- ▶ Healthcare providers tackle topics: trust from Soviet Era vaccines, comparing Moldovan and German ampoules, BCG as entry point, health insurance, triage, herd immunity
- ▶ Welcoming environment with toys or books for children, childcare provision, and presence of religious leaders or Roma mediators
- ▶ Tailored, easy-to-understand materials in Romani and Russian; assistance obtaining missing forms or documentation

Services would include childhood immunization, well-baby checkups, and open discussion sessions addressing very specific community concerns. Healthcare providers would tackle topics such as: drawing on trust from the Soviet Era by showing that current vaccines are the same as those from that period; improving perceptions of local vaccines by comparing ampoules from Moldova and Germany; using BCG vaccination as an entry point to discuss other vaccines; helping families understand time constraints providers face and contextualizing differences from care abroad; explaining health insurance requirements and available support; clarifying triage processes; and discussing herd immunity.

The environment would be welcoming and accessible, with toys or books for children, childcare provision, and the presence of religious leaders or Roma mediators to facilitate positive interactions. Elderly and disabled Roma would also be welcome. Families would have access to tailored, easy-to-

understand materials in Romani and Russian, as well as assistance obtaining missing forms or documentation to demonstrate unemployment or vulnerability status.

This solution addresses multiple barriers: respectful care and discrimination, information gaps, practical barriers related to understanding healthcare processes, and the need for trusted intermediaries to bridge provider-patient divides.

## SOLUTION 2 FAMILY HEALTH CIRCLES

**OBJECTIVE:** *To provide a dedicated space for women to openly discuss concerns related to health services and vaccination, ask questions, and receive accurate information in a supportive environment.*

- ▶ Regular gatherings in trusted community spaces — resource center in Soroca or mediator's office/mayor's building in Otaci
- ▶ Co-facilitated by Roma mediators alongside healthcare workers; coffee and snacks offered, fathers provide childcare
- ▶ Sessions address: health insurance and benefits, vaccine benefits and side effects, eligibility criteria, patient rights, appropriate behaviour during medical appointments
- ▶ Identify and elevate 'positive deviants' — mother leaders with positive vaccination experiences who provide testimonials to peers
- ▶ Mother leaders receive identifying markers (t-shirts or skirts) to signal their trusted role within the community
- ▶ Training for Roma mediators, social workers, and mother leaders on vaccination information with certificates upon completion
- ▶ Simple, visual materials developed in Russian, Romani, and Romanian to ensure accessibility

Family Health Circles would create regular gatherings where Roma women can discuss health concerns in trusted community spaces - such as the resource center in Soroca or the mediator's office or mayor's building in Otaci. Roma mediators would facilitate these sessions alongside healthcare workers, creating opportunities for dialogue in a culturally appropriate setting. To encourage participation, coffee and snacks would be offered, fathers could provide childcare during sessions, and participants could receive hygiene kits or items for babies and children.

Sessions would directly address sources of fears and concerns, including health insurance and benefits, vaccine benefits and side effects, eligibility criteria for vaccination, patient rights, and

appropriate behavior during medical appointments. The circles would also identify and elevate “positive deviants”- in other words, mother leaders who have had positive vaccination experiences and can provide testimonials to their peers. These mother leaders would receive identifying markers such as t-shirts or skirts to signal their role within the community.

Supporting activities include training Roma mediators, social workers, and mother leaders on basic vaccination information and frequently asked questions, with certificates provided upon completion. Simple, visual materials would be developed in Russian, Romani, and Romanian to ensure accessibility. By combining peer influence, trusted intermediaries, and accurate information in comfortable settings, Family Health Circles address multiple barriers simultaneously: misinformation, family influence dynamics, and lack of accessible information.

### SOLUTION 3 MEDIATOR SUPPORT AND INTEGRATION

**OBJECTIVE:** *To strengthen the relationship between Roma mediators and health facilities, elevate their role within both communities and institutions, and empower them to improve patient follow-up and vaccination information dissemination.*

- ▶ Focus on strengthening relationships between mediators and health facilities to engage mediators in patient follow-up efforts
- ▶ Shared vaccination calendar and reminder system co-managed by health facilities and Roma mediators
- ▶ Information sessions in trusted community venues: the church in Soroca and the mediator's office in Otaci
- ▶ Basic visual materials — vaccination calendars, updates, myth-debunking content — posted in high-visibility locations
- ▶ Podcast in Romani created in partnership with Tarna Rom to disseminate information; strategic use of Instagram and social media
- ▶ Capitalizes on existing enablers: mediators' cultural knowledge, community trust, and 'Roma mail' communication networks
- ▶ Creates sustainable infrastructure for ongoing health promotion beyond the life of the project

This solution recognizes that Roma mediators represent an underutilized resource whose potential can be unlocked through better training, clearer roles, and stronger institutional partnerships. Activities would focus on strengthening relationships between mediators and health facilities to specifically engage mediators in patient follow-up efforts and improve linkages between patients and healthcare providers.

A key component would be establishing a shared vaccination calendar and reminder system co-managed by health facilities and Roma mediators to support families in returning for scheduled vaccines. This addresses the practical challenge of maintaining contact with mobile populations and ensuring continuity of care despite migration patterns. Mediators would provide information sessions in trusted community venues—the church in Soroca and the mediator's office in Otaci.

Basic visual materials, including vaccination calendars, updates, and myth-debunking content, would be posted in high-visibility locations such as the main square in Roma Hill, Soroca. To leverage existing communication channels, a podcast in Romani would be created in partnership with Tarna Rom to disseminate information, alongside strategic use of Instagram and other social media platforms where Roma communities are already active.

This solution capitalizes on existing enablers - mediators' cultural knowledge, community trust, and "Roma mail" communication networks - while addressing the current barrier of mediators being excluded from healthcare systems and lacking adequate training. By elevating mediators' roles and equipping them with tools and institutional support, this intervention creates sustainable infrastructure for ongoing health promotion beyond the life of the project.

**Table 3** links these identified barriers to potential intervention approaches that could improve immunization uptake.

TABLE 3: COM-B ANALYSIS — KEY BARRIERS AND SOLUTION APPROACHES		
COM-B Component	Key Barriers	Solution Approach
<b>Capability</b>	Misinformation, limited health literacy, untrained mediators	<ul style="list-style-type: none"> <li>▶ Roma podcast</li> <li>▶ Visual materials in local languages</li> <li>▶ Accurate info dissemination, training programs</li> </ul>
<b>Opportunity (Physical)</b>	Distance, migration, payment barriers	<ul style="list-style-type: none"> <li>▶ Dedicated clinic times</li> <li>▶ Shared reminder systems</li> <li>▶ Documentation assistance</li> </ul>
<b>Opportunity (Social)</b>	Discrimination, mediator exclusion, strained relationships, family hierarchies	<ul style="list-style-type: none"> <li>▶ Roma-friendly clinic hours</li> <li>▶ Formal mediator integration</li> <li>▶ Safe dialogue spaces</li> <li>▶ Respectful provider protocols</li> </ul>
<b>Motivation</b>	Mistrust, fear, beliefs about vaccine quality	<ul style="list-style-type: none"> <li>▶ Positive experiences</li> <li>▶ Peer testimonials</li> <li>▶ Trust-building through respectful care</li> </ul>

## 6. EXPECTED OUTCOMES

The three interventions were co-designed in direct response to the COM-B behavioral diagnosis conducted through this study, which identified deficits in Capability (knowledge gaps, misinformation), Opportunity (eroded trust, structural barriers, family gatekeeping, weak mediator–clinic integration), and Motivation (fear rooted in negative past experiences, social norms that do not yet support local vaccination) as the primary drivers of low uptake. Together, they are designed to work in sequence and in combination. The first thing that needs to change is the experience of care itself. Until Roma families can attend a clinic and expect to be treated with respect, information and reminders alone are not enough to create behavior change - trust has to come before vaccination uptake can follow. Roma-Friendly Clinic Hours are therefore the entry point: regular, unhurried sessions where families are welcomed; questions are answered honestly, and no one is pressured. Over time, as families have more positive encounters and fewer reasons to avoid local services, attendance at local clinics is expected to rise and the pattern of seeking vaccination exclusively abroad should diminish.

At the same time, Family Health Circles work on the social environment around vaccination decisions. The research was unambiguous that mothers rarely decide alone - husbands and grandmothers are often the practical gatekeepers, and misinformation circulates through the same tight community networks that could just as easily carry accurate information. By creating a regular space where peer mother leaders share their own experiences, where myths are addressed directly, and where family members beyond the mother are explicitly invited and engaged, the circles aim to shift the default in families from hesitation to support. The measure of success here is not just individual knowledge but whether the socio-normative environment around vaccination begins to change - whether it becomes normal, expected, even socially endorsed, to vaccinate on time locally.

The third intervention addresses what happens between clinic visits. Migration disrupts schedules, phone numbers change, vaccination cards are lost, and children fall out of the system not because anyone decided against vaccination but because no one followed up. Strengthening mediator integration through training, shared vaccination calendars, reminder systems, and formal clinic–mediator operating agreements, is designed to close this gap. Families who are enrolled in the reminder system and have a trained mediator as a point of contact should complete vaccine series at higher rates, even though periods of mobility. The podcast in Romani and social media outreach extend this reach further, reinforcing messages through channels families already use and trust.

Together, these three strands are expected to produce meaningful improvement in timely immunization uptake among Roma children in Soroaca and Otaci within twelve months, alongside a measurable increase in caregivers' sense of safety and respect in clinic encounters. The longer-term goal, which consists of higher, more equitable childhood immunization coverage sustained beyond

the life of the project, depends on whether the changes to clinic culture and mediator integration become standing features of how the health system operates, rather than temporary program activities. That institutionalization is built into the design from the outset and is the primary criterion by which the success of this pilot should be judged.

## Evaluation Design

The PMF is designed to serve as the foundation for a prospective program evaluation, focusing primarily on implementation-related factors such as fidelity, feasibility, acceptability, and sustainability. Baseline data collection is planned for Month 0-1 of implementation, with a midline check at Month 6 and endline at Month 12. The evaluation will use a pre-post design within each pilot site, with key metrics including, for example, caregiver trust scores, vaccine series completion rates, and myth endorsement. A qualitative process evaluation strand, consisting of rapid check-in interviews, short focus group discussions and structured observation of clinic hours and circles, will run in parallel to explain quantitative trends and identify what is and is not working in practice. Findings will be used to refine the intervention package prior to any broader scale-up.

## 7. CONCLUSION

This study set out to understand why Roma children in Soroca and Otaci remain significantly under-immunized, and to co-design with the community itself the interventions most likely to change that. The answer that emerged is both humbling and actionable: the gap is not, at its core, one of vaccine hesitancy in the conventional sense. Roma families in these two communities largely believe in the value of vaccines. What they do not believe, according to the findings, is that the local health system will treat them with dignity, provide them with accurate information, or follow up when life disrupts their plans.

The three proposed interventions - Roma-Friendly Clinic Hours, Family Health Circles, and Mediator Support and Integration - address this reality directly. They do not ask Roma families to trust a system that has not yet earned that trust. Instead, they invest in changing the system's behavior first: making care respectful, making information accessible through people communities already trust, engaging the family members who actually make vaccination decisions, and giving mediators the training and institutional standing they need to serve as genuine bridges between families and health services.

Critically, this package was designed with the Roma communities, for the Roma communities. The solutions reflect two participatory workshops, 12 focus groups, and 30 in-depth interviews. Community members identified the barriers, validated the findings, and shaped the interventions. That process of co-design is itself a trust-building investment, and its value should not be lost in implementation. The legitimacy of these interventions depends on communities continuing to see themselves in them.

The twelve-month pilot in Soroca and Otaci represents a concrete, time-bound opportunity to demonstrate that this approach works, and to build the evidence base for potential replication across Moldova. The Performance Monitoring Framework provides the tools to learn rigorously as implementation proceeds and to make the case for scale-up to national government, donors, and health system partners.

Roma children in Soroca and Otaci deserve the same protection from vaccine-preventable disease as any other child in Moldova. Achieving that equity requires not more outreach campaigns, but a fundamentally different kind of relationship between the health system and these communities. This study has documented what stands in the way and, more importantly, what the communities themselves believe would improve vaccination as well as relationships with health services.

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