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PRACA ORYGINALNA
ORIGINAL PAPER

Experiences of discriminatory behavior in reproductive care: Preliminary study findings

Doświadczenia dyskryminacyjnego traktowania w opiece reprodukcyjnej – wstępne wyniki badania

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ABSTRACT

INTRODUCTION: Discrimination in healthcare often stems from biases related to gender, age, race, or disability. Among the vulnerable groups are women accessing reproductive care, such as prenatal testing, infertility treatment and perinatal care. These patients may experience various forms of unequal treatment, ranging from a lack of respect to the denial of medical procedures. Despite existing recommendations and legal regulations, discrimination remains a global issue. The aim of this study was to examine women's experiences of discrimination while accessing reproductive healthcare services.

MATERIAL AND METHODS: The study was conducted both online and in-person using a validated proprietary questionnaire. Inclusion criteria were: female gender, age ≥ 18 years, and use of reproductive healthcare services within the past 10 years. The study group consisted of 401 women. Data collection took place from June 1, 2024, to February 1, 2025. Statistical analysis was performed using Statistica 13.3, with statistical significance set at $p < 0.05$.

RESULTS: The majority of participants rated their experiences positively, however 28% reported instances of discrimination by medical staff. The most common issues included the use of inappropriate language, ignoring questions, or facial expressions indicating reluctance or disapproval. Additionally, 20% of respondents observed discriminatory behavior toward other female patients.

CONCLUSIONS: Despite many positive evaluations, the study revealed the presence of discrimination in reproductive healthcare. Both personal experiences and observations of such situations influence women's perception of the healthcare system and their sensitivity to inequality.

KEYWORDS

sexism, women, women's health, reproductive health

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STRESZCZENIE

WSTĘP: Dyskryminacja w ochronie zdrowia często wynika z uprzedzeń związanych z płcią, wiekiem, rasą czy niepełnosprawnością. Na dyskryminację narażone są również kobiety korzystające z opieki reprodukcyjnej, obejmującej m.in. dostęp do badań prenatalnych, leczenia niepłodności i opieki okołoporodowej. Pacjentki te mogą doświadczać różnych form nierównego traktowania – od braku szacunku po odmowę wykonania procedur. Mimo obowiązujących rekomendacji i regulacji prawnych problem dyskryminacji ma charakter globalny. Celem badania było poznanie doświadczeń kobiet w zakresie dyskryminacji w trakcie korzystania ze świadczeń opieki reprodukcyjnej.

MATERIAŁ I METODY: Badanie przeprowadzono online i stacjonarnie z wykorzystaniem autorskiego, zwalidowanego kwestionariusza. Kryteriami włączenia były: płeć żeńska, wiek ≥ 18 lat oraz korzystanie z opieki reprodukcyjnej w ciągu ostatnich 10 lat. Grupę badawczą stanowiło 401 kobiet. Badanie trwało od 1 czerwca 2024 r. do 1 lutego 2025 r. Analizę przeprowadzono w programie Statistica 13.3, przyjmując istotność statystyczną dla $p < 0,05$.

WYNIKI: Większość uczestniczek oceniła swoje doświadczenia pozytywnie, jednak 28% zgłosiło przejawy dyskryminacji ze strony personelu medycznego. Do najczęstszych należały używanie niestosownego języka, ignorowanie pytań lub mimika wskazująca na niechęć lub dezaprobatę. Dodatkowo 20% badanych zaobserwowało zachowania dyskryminacyjne wobec innych pacjentek.

WNIOSKI: Mimo wielu pozytywnych ocen badanie ujawniło również przypadki dyskryminacji w opiece reprodukcyjnej. Zarówno osobiste doświadczenia dyskryminacji, jak i obserwacje takich sytuacji wpływają na postrzeganie systemu ochrony zdrowia przez kobiety oraz na ich wrażliwość na nierówności.

SŁOWA KLUCZOWE

seksizm, kobiety, zdrowie kobiety, zdrowie reprodukcyjne

INTRODUCTION

The concept of discrimination refers to less favorable treatment based on gender, age, race, ethnic origin, religion, belief system, sexual orientation, or disability, in comparison to the treatment of another person in a similar situation [1]. According to Link and Phelan [2], discrimination is the final component of the stigmatization process, which begins with labeling human differences and associating them with negative stereotypes. Discrimination can occur on an interpersonal or direct level (i.e., in human relationships and everyday life) as well as on a structural or indirect level (i.e., through laws and regulations, policies, and constitutional practices) [2]. Discrimination against individuals in the healthcare sector and other settings stems from beliefs and prejudices related to gender, age, ethnic origin, disability, and other factors [3].

Reproductive care is directly related to two concepts: sexual and reproductive health. Sexual health is defined as a state of physical, emotional, mental, and social well-being in relation to sexuality, and not merely the absence of disease or dysfunction. This aspect of human health requires a positive and respectful approach to sexuality, as well as the possibility of having satisfying and safe sexual experiences, free from discrimination and coercion. Achieving sexual health requires respect for and protection of the sexual rights of all individuals [4]. Reproductive health is a state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions, and processes. Furthermore, according to the World Health Organization (WHO), the concept of reproductive health implies that individuals can lead satisfying and safe sexual lives, have the capability to reproduce, and have the freedom to decide if, when, and how often to have children [5].

WHO has identified five key areas of reproductive and sexual health. These include:

- improving prenatal, childbirth, postpartum, and neonatal care
- ensuring high-quality family planning services
- eliminating unsafe abortions that pose a risk to health and life
- combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer, and other gynecological conditions
- promoting sexual health [6].

Access to reproductive and sexual healthcare can have a significant impact on people's lives around the world. Achieving full reproductive and sexual health is an essential component of the highest attainable standard of mental and physical health. Access to such healthcare also supports human dignity and overall well-being [4]. The concept of reproductive care may encompass a wide range of health services and procedures, including access to contraception, prenatal testing, treatment of all conditions related to the female reproductive system, infertility treatment, pregnancy termination for various reasons, as well as childbirth and perinatal care [7,8].

Discriminatory behaviors toward women using reproductive care services manifest in various ways and may affect different groups of women. Women belonging to the LGBT (lesbian, gay, bisexual,

transgender) minority also experience prejudice from healthcare professionals in the context of reproductive care. Discriminatory attitudes among medical staff may include, for example, limited access to infertility treatment for same-sex couples or the refusal to perform gynecological examinations for transgender women [8]. Discriminatory behaviors toward recipients of medical services may vary depending on the type of healthcare professional involved and the setting in which the services are provided. Women receiving perinatal care may experience medical interventions to which they did not give consent and which lack medical justification, performed with the aim of shortening the duration of labor [9,10]. Outdated and non-recommended procedures are still being used in maternity wards, which can harm patients and lead to iatrogenic complications, for example, placing the laboring woman in the lithotomy position. Such practices may be perceived as a form of discrimination resulting from the improper delivery of healthcare services that fail to consider the needs, comfort, and choices of patients [10]. Other forms of discrimination related to reproductive care include delays in providing medical assistance, refusal to administer pain relief, lack of respect for patients' privacy, detaining women in medical facilities, and other similar practices [11,12].

Patients receiving reproductive care should remain in constant contact with the medical staff, who are obligated to provide accurate and comprehensive information. Smooth communication between doctors, nurses, midwives, and the patient is crucial to ensuring high-quality reproductive care, regardless of the healthcare setting. Unfortunately, in many cases, medical personnel ignore patients' questions or provide inconsistent and even insufficient answers [13,14]. There are situations in which patients encounter insults, verbal abuse, or comments intended to reprimand or hurt their feelings. In some cases, they are victims of verbal violence. Specialists often assume that women's health conditions result from their lifestyle rather than from various diseases or disorders. The use of unprofessional and offensive language during interactions with patients, as well as dismissing the health problems they present, is also problematic [15]. Discrimination in access to reproductive healthcare services can also occur at the institutional and legal levels. According to Article 68 of the Constitution of the Republic of Poland, "everyone has the right to health protection, and public authorities are obliged to provide special healthcare, including for pregnant women" [16]. Health security and its stability are inseparably linked to the right to health protection, as both concepts are connected to the personal dignity of the individual [17].

The aim of the study was to assess women's experiences of discrimination while using reproductive healthcare services.

MATERIAL AND METHODS

The study was conducted using a dual approach, both in-person and remotely, through a custom questionnaire. The data was collected using a survey questionnaire administered both in a traditional paper-based format (paper and pen interview – PAPI) and online computer-assisted web interview – CAWI), which enabled access to a diverse group of respondents. The online version of the questionnaire was shared on social media platforms such as Facebook and Instagram. Submission of a completed questionnaire was considered equivalent to providing informed consent to participate in the study. Inclusion criteria were: age $\geq$ 18 years, identifying as female, and having used reproductive healthcare services within the past 10 years. In this study, two sampling methods were employed: random sampling and convenience sampling. A total of 401 women participated in the study. The research was conducted between June 1, 2024, and February 1, 2025. Data analysis was performed using Statistica for Windows version 13.3, applying descriptive statistics and comparative tests (chi-square test). Results were considered statistically significant at a p-value of < 0.05. It is important to note that the study sample was not representative at the national level.

RESULTS

The demographic profile of the respondents, including age, place of residence, education level, relationship status, sexual orientation, and number of children, is presented in Table I. The average age of respondents was 27 years. The largest group of respondents lived in cities with populations over 100,000. In terms of education, the most commonly reported level was secondary education (53%). Notably, 13% of respondents identified as non-heteronormative. Additionally, the majority of respondents did not have children (76%).

Participants assessed their past experiences with reproductive healthcare on a scale from 1 (very poor) to 5 (very good). The most frequently selected rating was 3 (n = 158), followed closely by a rating of 4 (n = 145). Significantly fewer respondents chose ratings of 2 and 5 (45 and 41, respectively). The least frequently selected rating was 1 (n = 12).

Participants were also asked which healthcare specialists they had consulted over the past 10 years.

This was a multiple-choice question. The majority of respondents reported using the services of a gynecologist or gynecological clinic (63%). Seventeen percent had visited an endocrinologist or an endocri-nology clinic, and 11% had seen an obstetrician-gynecologist. A smaller proportion of women had consulted a dietitian specializing in endocrine disorders (3%) or a urogynecological physiotherapist (3%).

Respondents were asked about the reasons for receiving reproductive healthcare. This was a multiple--choice question. The most frequently indicated reasons were hormonal disorders (n = 89) and other health problems (n = 93). Commonly reported reasons also included hypothyroidism or hyperthyroidism (n = 85), polycystic ovary syndrome (PCOS; n = 55), and perinatal care (n = 53). Other reasons included endometriosis (35 responses), insulin resistance (32 responses), and other endocrine disorders (30 responses). The responses are presented in Table II.

Participants were asked whether they had experienced discriminatory behavior from healthcare professionals. The vast majority of women reported no such experiences. However, 28% of respondents answered affirmatively.

Women who reported experiencing discriminatory behavior were asked to specify the types of behaviors they encountered. This was a multiple-choice question. The most commonly reported experience was facial expressions indicating aversion or disgust (70 responses). Other frequently reported behaviors included ignoring questions or requests (50 responses), use of offensive language, insults, or name-calling (46 responses), refusal to provide medication or anesthesia (12 responses), and performing medical procedures without consent or prior information (11 responses). The responses are presented in Table III.

Table I. Demographic characteristics of respondents

Sociodemographic data		Total n = 401 (100%)
Age groups	18–27 years	286 (71%)
	28–37 years	57 (14%)
	38–47 years	38 (9%)
	48–57 years	14 (3%)
	58 years and older	6 (1%)
Place of residence	Village	47 (12%)
	City under 20,000 inhabitants	38 (9%)
	City of 20,000–100,000 inhabitants	105 (26%)
	City over 100,000 inhabitants	211 (53%)
Education level	Vocational	5 (1%)
	Secondary	212 (53%)
	Higher	181 (45%)
	Postgraduate (PhD, habilitation)	3 (1%)
Relationship status	Single	143 (36%)
	In a partnership	162 (40%)
	Married	81 (20%)
	Widowed	3 (1%)
	Divorced	12 (3%)
Sexual orientation	Heterosexual	347 (87%)
	Homosexual	11 (3%)
	Bisexual	41 (10%)
	Other	2 (1%)
Number of children	No children	305 (76%)
	One child	46 (11%)
	Two children	38 (9%)
	Three or more children	12 (3%)

Table II. Reasons for receiving reproductive healthcare

Response	Number of responses n = 585 (100%)
Infertility, fertility disorders	18 (3%)
Difficulty maintaining pregnancy, miscarriages	16 (3%)
Hypothyroidism or hyperthyroidism	85 (15%)
Ovarian dysfunction (hypofunction or hyperfunction)	13 (2%)
Polycystic ovary syndrome (PCOS)	55 (9%)
Other endocrine disorders	30 (5%)
Hormonal disorders (e.g., hyperandrogenism, hyperestrogenism)	89 (15%)
Endometriosis	35 (6%)
Insulin resistance	32 (5%)
Diabetes	12 (2%)
Excess body weight	39 (7%)
Reproductive organ cancers	15 (3%)
Perinatal care	53 (9%)
Other	93 (16%)

Table III. Discriminatory behaviors experienced by respondents

Experienced behavior	Number of responses n = 209 (100%)
Facial expressions suggesting aversion or disgust	70 (33%)
Ignoring questions or requests	50 (24%)
Offensive language, insults or name-calling	46 (22%)
Refusal to provide medication (e.g., painkillers, sleeping pills) or anesthesia	12 (6%)
Performing medical procedures without consent or prior information (e.g., episiotomy)	11 (5%)
Refusal to perform specific procedures	7 (3%)
Pushing, shoving, or other behavior suggestive of physical abuse	6 (3%)
Other	4 (2%)
Deliberate delay in performing procedures	3 (1%)

The respondents were asked to indicate specific medical professions whose representatives behaved inappropriately. The most frequently mentioned were doctors and nurses – these responses were marked 87 and 56 times, respectively. The obtained results are presented in Table IV.

Table IV. Medical professions identified as source of inappropriate behavior

Profession	Number of responses n = 165 (100%)
Doctor	87 (53%)
Nurse	56 (34%)
Midwife	15 (9%)
Dietitian	3 (2%)
Psychologist	2 (1%)
Physiotherapist	1 (1%)
Other	1 (1%)

All participants in the study were asked whether they had witnessed situations in which another patient experienced discriminatory treatment. As many as 20% of the respondents confirmed that they had observed such behavior towards other women. Women who had witnessed discrimination against other patients were then asked to answer the next question, what undesirable situations they had observed. This was a multiple-choice question. The most frequently noticed situations were: facial expressions suggesting reluctance or disgust (n = 54), ignoring questions or requests (n = 40), and offensive language, insults, and name-calling (n = 36). The remaining responses are presented in Table V.

A statistical analysis was conducted to examine the relationship between respondents' evaluations of their reproductive healthcare experiences and their exposure to discriminatory behavior. The results indicate a very strong statistical association between

responses to these two questions (p = 0.00001). Detailed results of the analysis are presented in Table VI.

Table VII presents the results of an analysis examining the relationship between responses to the question: Do you believe there is a difference in the quality of reproductive healthcare services depending on the patient's gender?, and two grouped variables: number of children and age. The statistical analysis revealed significant associations between these variables.

The next part of the questionnaire included questions presented in table form, using a 5-point scale where 1 meant "strongly disagree" and 5 meant "strongly agree." Most respondents believe that women are discriminated against in healthcare (n = 175), although a significant number of participants selected the neutral option 3, meaning "no opinion" (n = 109). Additionally, the majority of participants (n = 314) believe that women with conditions affecting their physical appearance are more likely to experience stigmatization. A large portion of the surveyed women think that women do not have more difficulty accessing necessary medical services compared to men (n = 161). A clear majority of respondents agreed with the statement that medical staff downplays the pain experienced by female patients (n = 267). All the responses obtained are presented in Table VIII.

Table V. Discriminatory behaviors observed by respondents towards other patients

Experienced behavior	Number of responses n = 172 (100%)
Facial expressions suggesting aversion or disgust	54 (31%)
Ignoring questions or requests	40 (23%)
Offensive language, insults or name-calling	36 (21%)
Refusal to provide medication (e.g., painkillers, sleeping pills) or anesthesia	15 (9%)
Performing medical procedures without consent or prior information (e.g., episiotomy)	9 (5%)
Pushing, shoving, or other behavior suggestive of physical abuse	7 (4%)
Refusal to perform specific procedures	5 (3%)
Deliberate delay in performing procedures	5 (3%)
Other	1 (1%)

Table VI. Relationship between the evaluation of reproductive healthcare experiences and exposure to discrimination by healthcare workers

Have you experienced discriminatory behavior from healthcare workers?	Response to the question: On a scale of 1 to 5, how would you rate your reproductive healthcare experiences so far?					Total	chi²-value	p-value
	1	2	3	4	5			
No	8 (3%)	20 (7%)	109 (38%)	118 (41%)	35 (12%)	290 (100%)		
Yes	4 (4%)	25 (23%)	49 (44%)	27 (24%)	6 (5%)	111 (100%)	27.97	0.00001
Total	12 (3%)	45 (11%)	158 (39%)	145 (36%)	41 (10%)	401 (100%)		

Table VII. Associations between the variables "number of children" and "age" and the perception of gender-based differences in reproductive healthcare quality

Number of children	Response to the question: Do you believe there is a difference in the quality of reproductive healthcare services depending on the patient's gender?					Total	chi²-value	p-value
	1	2	3	4	5			
None	20 (7%)	47 (15%)	130 (43%)	70 (23%)	38 (12%)	305 (100%)		
1 child	4 (9%)	8 (17%)	26 (57%)	5 (11%)	3 (7%)	46 (100%)		
2 children	2 (5%)	12 (32%)	22 (58%)	2 (5%)	0 (0%)	38 (100%)	16.88	0.00204
3 or more children	2 (17%)	2 (17%)	5 (42%)	2 (17%)	1 (8%)	12 (100%)		
Total	28 (7%)	69 (17%)	183 (46%)	79 (20%)	42 (10%)	401 (100%)		

cd. Tabeli VII

Age group (years)	Response to the question: Do you believe there is a difference in the quality of reproductive healthcare services depending on the patient's gender?					Total	chi²-value	p-value
	1	2	3	4	5			
18–27	17 (6%)	44 (15%)	119 (42%)	68 (24%)	38 (13%)	286 (100%)	35.30	0.00361
28–37	4 (7%)	14 (25%)	30 (53%)	7 (12%)	2 (4%)	57 (100%)		
38–47	6 (16%)	6 (16%)	22 (58%)	4 (11%)	0 (0%)	38 (100%)		
48–57	1 (7%)	4 (29%)	9 (64%)	0 (0%)	0 (0%)	14 (100%)		
58 and older	0 (0%)	1 (17%)	3 (50%)	0 (0%)	2 (33%)	6 (100%)		
Total	28 (7%)	69 (17%)	183 (46%)	79 (20%)	42 (10%)	401 (100%)		

Table VIII. Questions conducted using a 5-point scale

Questions	Number of responses 1	Number of responses 2	Number of responses 3	Number of responses 4	Number of responses 5
Do you believe that women are discriminated against in healthcare?	31	86	109	121	54
Do you believe that women suffering from conditions affecting physical appearance (e.g., PCOS and other hormonal disorders, obesity) are more likely to experience stigmatization?	11	21	55	202	121
Do you believe that women have more difficulty accessing necessary medical services (e.g., quick diagnosis, administration of anesthesia before painful procedures) compared to men?	55	106	108	77	55
Do you believe that women have more difficulty accessing necessary medical services (e.g., during childbirth, curettage, IUD insertion)?	15	53	66	149	118
Do you believe that reproductive care for women struggling with fertility disorders is properly organised?	62	118	181	33	7
Do you believe that reproductive care for women after misscarriage or stillbirth is properly organised?	98	120	158	18	7
Do you believe that women have equal access to information about reproductive care?	47	118	127	77	32
Do you believe that women have access to contraception (e.g., hormonal contraception, morning-after pill, IUD insertion)?	71	101	52	134	43
Do you believe there is a difference in the quality of reproductive healthcare services depending on the patient's gender?	28	69	183	79	42

PCOS – polycystic ovary syndrome; IUD – intrauterine device

DISCUSSION

The phenomenon of discrimination against patients using various healthcare services poses a serious challenge that requires a multifaceted and in-depth analysis. Conducting research that takes into account the specific characteristics of different patient groups (e.g., gender, race, ethnic background) is particularly important because experiencing discriminatory attitudes and behaviors can negatively affect health through psychological and physiological stress responses, as well as through adverse health behaviors that lead to a deterioration in overall health [18]. To counteract discrimination against women, it is necessary to document experiences among broad

groups of women in various areas of life. Participants in the original study were asked to rate their reproductive healthcare experiences so far using a 5-point scale, where 1 meant "very bad" and 5 meant "very good." The highest number of responses were recorded at levels 3 (n = 158) and 4 (n = 145), which may indicate a moderate level of satisfaction. At the same time, these results point to areas that require improvement in the quality of care provided.

The respondents were asked whether they had encountered discriminatory behavior from healthcare workers. Twenty-seven percent of the women surveyed answered affirmatively. Similar results were reported in a study conducted by SteelFisher et al. [18], in which one in five women reported experiencing gender-based discrimination during a visit to a doctor or healthcare facility. Comparable findings were also presented in a study by Nong et al. [19], where 21.4% of participants admitted to experiencing discriminatory attitudes and behaviors within the healthcare system. Furthermore, this study showed that women were particularly vulnerable to discriminatory behavior.

Respondents who reported experiencing discriminatory behavior in the study were asked to answer several follow-up questions, including those regarding the nature of these behaviors and the professions of the staff members who committed them. The most frequently reported forms of discrimination by patients were: facial expressions from the staff suggesting reluctance or disgust (n = 70), ignoring requests or questions (n = 50), and the use of offensive language and insults (n = 46). In the original study, the highest number of reports concerned doctors (n = 87), nurses (n = 56), and midwives (n = 15). Different results were presented in a study by Lansky et al. [11], which focused on the experiences of pregnant women. There, the most common forms of discrimination were performing medical interventions without patient consent or after consent given based on incomplete or distorted information, verbal abuse, and physical violence. Available research indicates that discriminatory behaviors can be carried out by various professional groups, including doctors, nurses, and midwives. It is important to emphasize that the presence of such attitudes is not always a result of faulty beliefs or prejudices. It may stem from a sense of superiority, the culture prevailing in healthcare facilities, or the overburdening of medical staff [11,19,20,21].

All participants had the opportunity to answer whether they had witnessed cases of discrimination against other patients using reproductive healthcare services. Twenty percent of respondents answered affirmatively. Women who reported witnessing discrimination most often observed situations where another patient was met with facial expressions from staff suggesting reluctance or disgust (n = 54), ignoring of questions or requests (n = 40), the use of offensive language or insults (n = 36), as well as refusal to administer medications such as painkillers, sleeping aids, or anesthesia (n = 15). It is worth noting that the percentage of participants who personally experienced discrimination is comparable to the percentage of those who witnessed it.

The next part of the questionnaire included questions presented in table form, using a 5-point scale. The purpose of this section was to examine the participants' views and opinions regarding discrimination in the healthcare sector. The study participants were asked whether they believed that women are discriminated against in the healthcare system. A total of 175 respondents selected either 4 ("agree") or 5 ("strongly agree") on a 5-point scale. A significant portion of the respondents chose the neutral option, 3, which indicates "no opinion." The results may be partially influenced by the demographic and social characteristics of the study group. In addition to an increased risk of gender-based discrimination, young women, individuals with excess body weight, as well as those with lower socioeconomic status, may be particularly vulnerable to unfavorable treatment when interacting with the healthcare system. Furthermore, women who have experienced or witnessed discriminatory behavior in the context of reproductive care may be more sensitive to such attitudes and may have developed a specific worldview, which can affect how they interpret and assess situations within the healthcare system [17,22].

Some medical conditions, either directly or indirectly related to endocrinology or gynecology, may affect a person's physical appearance. This group of conditions includes obesity, which results in visible accumulation of body fat, as well as hormonal disorders and gynecological diseases such as PCOS and associated conditions like hyperandrogenism or hypertestosteronemia, which can lead to symptoms such as hormonal acne or hirsutism (excessive male-pattern hair growth) [23,24]. The respondents were asked to express their opinion on the statement: Are women suffering from conditions that affect their physical appearance (e.g., PCOS, hormonal disorders, obesity) more likely to experience stigmatization? The vast majority of participants (n = 314) agreed with this statement (responses 4 and 5). This result may stem from the respondents' personal experiences or situations they have witnessed. Research suggests that individuals with conditions affecting physical appearance may be particularly vulnerable to discrimination and stigmatization. It is worth noting

that such attitudes often arise from prejudice, gender stereotypes, or a lack of understanding about the causes and characteristics of the given condition [13,25].

This study encountered several limitations related to the surveyed group. First and foremost, all questionnaires were entered into a single database, which made it impossible to conduct analyses distinguishing between responses collected online and those collected in person. As a result, it was not possible to provide an in depth description of the findings that accounted for potential differences between participants who took part in the study remotely versus those who did so in person, differences that could have potentially influenced the responses obtained. Another limitation was the difficulty in finding comparable studies of a similar nature. Due to the specific focus of this research – namely, gender-based discrimination in healthcare – most of the available literature addressed multi-factorial discrimination, such as that involving both gender and race. This made it challenging to directly relate the findings of this study to those of other authors.

CONCLUSIONS

1. The majority of the women surveyed assessed their experiences with reproductive healthcare as positive.
2. Despite the overall positive evaluation, the collected data clearly suggest the presence of certain instances of discrimination within reproductive care.
3. The most frequently reported forms of discrimination included facial expressions from medical staff suggesting reluctance or disgust, the use of offensive language, and ignoring patients' questions or requests.
4. The perception of discriminatory behavior among participants in the study was shaped by factors such as age, number of children, sexual orientation, and declared relationship status.
5. There is a need to undertake in depth research that will provide better insight into the nature of experienced discrimination and the mechanisms behind its emergence.

Authors' contribution

Study design – M. Szymańska, P. Romaniuk
Data collection – M. Szymańska
Data interpretation – M. Szymańska
Statistical analysis – M. Szymańska
Manuscript preparation – M. Szymańska, P. Romaniuk
Literature research – M. Szymańska

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