JSI ROMANIA RESEARCH AND TRAINING INSTITUTE
CENTER FOR HEALTH POLICIES AND SERVICES

RESEARCH-EVALUATION OF THE HEALTH MEDIATORS PROGRAM WITHIN ROMA COMMUNITIES IN ROMANIA

- 2006-

EXECUTIVE SUMMARY

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This study is part of the project "Increased Access of Roma Communities to Family Planning and Reproductive Health Services", within the program called "Romanian Family Health Initiative", a USAID-funded program implemented by JSI Research & Training Institute.

CONTENTS

1. FOREWORD

This assessment was carried out by the JSI Research & Training Institute, in partnership with the Center for Health Policies and Services (CHPS), within the USAID-funded program "Romanian Family Health Initiative", at the request of the Ministry of Health (through the Healthcare General Directorate – the "Mother and Child" Department) in November 2004. Only one assessment of this program has been conducted so far (2001), based on which the program was adopted and replicated by the Health Ministry throughout the country. Afterwards, two other assessments were conducted by Romani CRISS (Roma NGO, initiator of the mediation program in Romania) and the Ministry of Public Health, each with its own specific nature, which yet again highlighted to the decision-makers the importance of this intervention for Roma communities.

Furthermore, the assessments showed that, in spite of the difficulties encountered in implementing and especially developing the projects, the Roma health mediator program can be seen as an example of an excellent partnership between government structures (both nationally and locally), non-government organizations and national and international donors. From the beginning, their contribution is an absolute must, because it is only through their technical and financial support, by establishing partnerships, that a health mediator can be professionally and institutionally prepared to cope with community needs and gain visibility within the community and society.

This research is aimed at highlighting health mediators' activities and efforts, as well as identifying the needs of the Health Mediator Program in key professional development areas (tasks and responsibilities, professional training and equipment, interaction, monitoring / evaluation, outcomes and impact within the communities and in the socio-medical system). We hope that our conclusions and recommendations will contribute to supporting and redefining the program amid the upcoming health and social reforms.

Above all, the assessment has shown that health mediators represent more than that which is set forth in the law: they are socio-medical mediators, but especially intercultural mediators, the communication link between the Roma and the national cultures. Regarded merely as a "temporary" figure as part of the reform period of the Romanian health system and the transition of the Roma minority towards an acknowledged ethnic status, the health mediator is one of the first steps in the development of the Roma community, creating confidence and dialogue between the community and public services.

For the drafting of this study we express our gratitude to the Center for Health Policies and Services, Ms. Hanna Dobronăuțeanu, M.D. – Adviser to the Health Minister on Roma health issues, Ms. Mariana Buceanu – trainer, Mr. Daniel Rădulescu – coordinator of the Romani CRISS health department, ASP coordinators in the eight selected counties, to all health mediators, family doctors within Roma communities, the representatives of County Offices for Roma people, the local authorities and organizations involved. Special acknowledgement must be extended to the health mediators, whose strenuous efforts continue to help improve their communities' health condition.

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2. ROMANIAN FAMILY HEALTH INITIATIVE

During the past seven years, the cooperation between Romanian and international organizations (JSI Research & Training Institute included) has materialized in two reproductive health surveys among the general population and certain social groups, including the Roma (Reproductive Health Survey – Romania, 1999 and 2004). The collected data helped establish healthcare priorities in areas such as family planning and reproductive health (FP/RH). Against this background, in November 2001 the USAID-funded program "**Romanian Family Health Initiative**" (RFHI) was launched, implemented by the JSI Research & Training Institute in partnership with the Ministry of Health. This program is aimed at increasing access to and the use of FP/RH services by women of reproductive age, particularly impoverished and disadvantaged women. .

One of the RFHI components targets the Roma population, faced with numerous and complex health issues, brought about by insufficient access to information, missing identity papers, lack of health insurance, etc.

The project ***"Increasing the access of Roma communities to FP/RH services"***, conducted during November 2004 – January 2007, was aimed at increasing access to and the use of FP/RH services by Roma community members, by technically and financially supporting the intervention regarding Roma Health Mediators (RHM) within the National Health Program No. 2.

During the two years of the project, some 177 RHM were trained in FP/RH, along with 13 mediators-trainers in 20 counties, spanning over 200 urban and rural communities. Training was carried out based on a specific curricular package, focusing on interactivity and simplicity, including topics such as the anatomy of the reproductive system, family planning methods, pregnancy and prenatal care, tending to the newborn, sexually-transmitted infections, breast and cervical cancer.
In addition, health mediators received all the necessary equipment for conducting their outreach activities, including the relevant equipment for professional identification.
More than 6,800 training sessions were held in the 200 communities, using customized information-education-training tools and materials, specially tailored to the Roma culture and status.
Furthermore, some 111 family doctors (FD) from 6 counties attended workshops on the diversity of Roma culture and intercultural communication.

This RFHI intervention, along with those of other organizations and implementing national health programs, is a genuine investment which is expected to yield significant results over the long run: improving the health condition of Roma communities.

3. BACKGROUND – A BRIEF HISTORY OF THE HEALTH MEDIATORS PROGRAM WITHIN ROMA COMMUNITIES

The concept of the health mediator within Roma communities originated in the Roma NGOs, whose structures were still in their infancy in the early 90s.

Since 1993, Romani CRISS has initiated several programs aimed at improving the health condition of the Roma population and their access to public services. The health programs conducted by Romani CRISS focus on enhancing all aspects of the health condition of members of Roma communities in Romania. The guidelines of the conducted projects centered at all times on better communication between the medical authorities and Roma communities. Against this backdrop, the initiative emerged to train Roma women with an average educational background in the health mediation field.

The partnership promoted by Romani CRISS with the Ministry of Health facilitated both the development and the implementation of the health mediation program and cooperation among Roma communities and local institutions of the Ministry of Health (Public Health Authorities). Thus, on 14 August 2002, the Health Minister issued Order No. 619 on "approving the health mediator trade and the technical norms governing the organizing, functioning and financing of health mediators' activity in 2002", under the framework of objective 2 of intervention 12 – Promoting the health of women and children at community level – within the Child and Family Health National Program. Based on this Order, health mediators are employed over a defined period of time in healthcare facilities financed from extra-budgetary revenues.

The Order specifies that "the primary role of health mediators is to facilitate communication between Roma communities and the medical staff, thus helping to streamline public health interventions", hence improving the social and medical standing of the Roma people. Health mediators are the persons supporting the medical staff in conducting healthcare-related activities. They not only facilitate dialogue between the community and medical staff, but also strengthen ties among the local authorities and the Roma community, by identifying the latter's health issues and monitoring diseases occurring among the persons in the community. The mediator's fundamental role is to significantly contribute to enhancing the community's health condition, by facilitating the doctor-patient relationship, increasing accessibility to health services, enhancing the efficiency of preventive and curative services, improving the social context in which the public health services are carried out, as well as raising the level of Roma's health education.

Furthermore, as a result of extensive advocacy efforts from Romani CRISS, the Ministry of Labor and Social Solidarity have now included the health mediator trade in the Classification of Occupations in Romania. It is acknowledged under Base Group 5139 "Workers servicing households", code 513902. The RHM recruitment and training system is based on recommendations from Roma organizations active in the community, after which candidates are trained and tested with a view to being accredited as health mediators. During 2002-2005, Romani CRISS, the organization assigned with the task of training health mediators, trained – through trainers acknowledged by the Ministry of Health – some 395 health mediators, who became actively involved in Public Health Authorities at county level.

The Health Mediators Program within Roma Communities is currently conducted in 38 counties, with 288 health mediators actively involved.

Under the formal framework governing RHM activity, health mediators cooperate closely at the local level with family doctors whose patient lists include Roma. Moreover, they cooperate with local public authorities (Mayor's Office, school a.o.) – particularly with a view to solving legal or social matters identified within the community. At each county level, RHMs are coordinated by a coordinator from the Public Health Authority appointed for this purpose.

4. THE METHODOLOGICAL DESIGN OF RESEARCH-EVALUATION

PURPOSE OF EVALUATION

The purpose of evaluation is to examine the implementation and impact of the Health Mediation Program in Romania, as conducted until end-2006, with a view to planning the upcoming interventions for developing this program and integrated medical and social services at the level of Roma communities by the Ministry of Public Health and the Health Management and Public Health National School.

OBJECTIVES OF EVALUATION

A. Assessing the adequacy and the consistency of the RHM activities terms of reference, as laid out in the legal framework governing the job description, with their day-to-day activities.

B. Assessing the support provided to RHM with a view to completing the current activities:

a. training program: areas of interest, contents, trainers, length, training needs still to be addressed, estimating the minimum costs required for developing a more detailed training plan, devising a long-term training strategy;

b. the current stage of material endowment and any equipment needs still to be addressed;

C. Assessing the actual RHM position in the relationship with:

a. Coordinators of the RHM program at the level of the Public Health Authorities (ASP);

b. Health service providers at community level (family doctors) for an enhanced integration of services community-wide.

c. Program beneficiaries.

D. Assessing the RHM contribution to ensuring access of impoverished people from Roma communities to health services in general and to reproductive health services in particular.

E. Assessing the quality of the current system for monitoring and evaluating the RHM program/activities.

Given the complexity of information to be collected and analyzed, as well as the context in which the implementation of the Program "***Developing the health mediators system within Roma communities"*** is assessed, the research-evaluation methodology consists of several components, aimed at a complex approach combining quantitative and qualitative methods and addressing all professional categories involved in the RHM Program, namely beneficiaries, implementers, coordinators and sponsors.

TARGET POPULATION AND RESPONDENTS:

With a view to attaining the proposed objectives and drawing an accurate overall picture of the way in which the RHM program is currently running, the survey included several professional categories involved as follows:

- Coordinators of the RHM program at the level of the Public Health Authorities.
- Representatives of County Offices for Roma population within the Prefect's Office.
- RHMs.
- Health service providers at community level (family doctors).
- Direct beneficiaries of the program.
- Representatives of local Roma NGOs and local public authorities (Mayor's Office, social care departments, etc.) involved in RHM activities.
- Representatives of Romani CRISS.
- The Health Minister's counselor on Roma matters.

1. The qualitative component of research – evaluation: methods, tools, respondents

The qualitative component consisted of **case studies with direct beneficiaries and in-depth interviews** with professionals, RHM and other persons in charge of conducting the Health Mediation Program in Romania. Eight counties were selected – one from each development region, namely: Vaslui, Brăila, Ilfov, Braşov, Bistrița, Călăraşi, Dolj, Timiş. The unfolding of the RHM program was examined in detail at each county level, by conducting in-depth interviews with representatives of the authorities, of the civil society at county level, as well as by selecting a Roma community where interviews were held with RHM, family doctors and other representatives of the local authorities (Mayor's Office, school, etc.), and community members. Roma communities from each county were selected based on the following criteria:

- The population of the Roma community was large.
- The community-active RHM had at least one year of experience in that Roma community.

During the research, the following interviews and case studies were conducted at county level:

- 8 interviews with ASP representatives in charge of RHMs.
- 6 interviews with representatives of County Offices for Roma population.
- 6 interviews with representatives of the local public authorities (Mayor's Office, social care departments, Regional Office of the National Roma Agency/local Roma NGOs/ representatives of the local school).
- 10 interviews with RHMs.
- 11 interviews with family doctors.

- 9 case studies within Roma communities, with the direct beneficiaries.

Furthermore, interviews were conducted at a central level with:

- The Health Minister's counselor on Roma matters.
- The representative of Romani CRISS foundation.

As regards the actual implementation of the qualitative component of research – evaluation, the interviews were conducted by experienced operators and they were audio-taped. The interview transcripts were then materialized into synthetic interview protocols for each distinct interview.

Upon preparing the final research – evaluation report, interviews were analytically and synthetically processed and grouped into content chapters defined according to the general objectives of research – evaluation. Each chapter analytically describes the key results obtained, followed by the synthetic conclusions relating to these analytic results and conferring an integrated perspective. Based on the synthetic conclusions from each chapter, the end of the report comprises distinct chapters with overall conclusions and recommendations for application.

2. The quantitative component of research – evaluation: methods, tools, samples

Two questionnaire-based sociological surveys were devised and then implemented on two samples of respondents corresponding to the most important categories of stakeholders directly involved in the RHM Program, namely: Roma health mediators and family doctors. As regards the sociological survey targeting the RHM population, it should be mentioned that we are actually dealing with a quasi-exhaustive research on this population in its entirety, and not merely a sample research. As for the sociological survey targeting family doctors, we are actually dealing with a sample of counties (two from each development region, chosen at random), because in the selected counties the FD population working with RHM was subject to a quasi-thorough research.

The questionnaires were addressed to:

- Roma health mediators within counties where they carry out their activity (38 counties, 241 questionnaires filled out, out of the total RHM population of 288, ie. a response ratio of 84 percent).
- Family doctors; two counties were chosen at random from each of the 8 development regions. Some 408 family doctors working with, cooperating or having cooperated with RHM were identified in the 16 counties. Some 408 questionnaires were sent to family doctors, out of which 325 were returned duly filled out, giving a return ratio of 80 percent.

Data analysis was performed by using specialized statistical processing software, namely SPSS.

5. BRIEF ANALYSIS OF RESULTS

5.1 Assessing the degree to which RHM terms of reference are adequate and consistent with the day-to-day activity

RHM's role in the community and their field activity

Both family doctors and health mediators consider that the most important roles of Roma health mediators within the community are enhancing the awareness of the Roma population with regard to health issues (30 percent of family doctors and 37 percent of Roma health mediators) and facilitating communication between the Roma and family doctors or the authorities (29 percent of family doctors and 29 percent of Roma health mediators).

The RHM job description currently includes healthcare and assistance as main tasks, with a special focus on the health of mothers and children. Out on the field, however, health mediators have to cope with numerous issues, well beyond the medical sphere, relating mainly to the social field. The RHM activity largely hinges on social matters, some of them without any direct connection to the medical tasks elaborated in the job description.

RHM activities in the social sphere consist particularly of the services provided to beneficiaries so that the latter might address the situation of missing identity papers or enjoy the relevant social care rights required for being included on the list of a family doctor. In addition, several mediation and "social negotiation" activities are carried out with representatives of local schools or authorities for settling any outstanding social problems (for instance, enrolling children for courses, activities aimed at preventing school abandonment and school reintegration for those who had previously quit, placing children from impoverished families in foster care, obtaining financial rights for physically- or mentally-impaired persons, etc.).

RHM activities in the health field consist of properly informing and providing guidance to pregnant and childbed women, as well as supervising newborns, promoting family planning services and information and training on major public health issues. Both family doctors and health mediators consider that the most important RHM tasks are mobilizing people for the vaccination program (23 percent of family doctors and 38 percent of Roma health mediators) and a proper census of the Roma population (18 percent of family doctors and 35 percent of Roma health mediators). The census conducted by RHM is aimed particularly at children and pregnant and childbed women, although it does not necessarily exclude a more extensive census covering almost the entire community they service.

Roma health mediators also play an important role in raising the awareness of Roma women regarding to FP services; indeed, an increasing number of Roma women of fertile age have confidently resorted to family planning of late. Moreover, RHM are active in tending to mothers and children. Information activities aimed at raising awareness of other public health issues are covered to a much lower extent and hence they cannot be looked upon as constant activities.

The role of Roma health mediators, at least in the three above-mentioned directions (monitoring of pregnant women and newborns, FP counseling and mobilizing the community for vaccination), is undoubtedly an extremely important one, sometimes yielding truly spectacular results.

Furthermore, activities related to TB control and prevention are also important (directly observed treatment, identifying contacts, guidance for testing). Many a time, however, RHM are faced with medical issues beyond their tasks concerning public health or the health of mothers and children (senior citizens, physically- or mentally-impaired persons, persons with chronic diseases, etc.).

Another important thing is that RHM also involve themselves in solving the problems of impoverished individuals from the majority population or from other minorities.

The link between the RHM's on-site activity and the tasks laid down in their job description

One may safely assume that the RHM activity is overburdened from both a quantitative and a qualitative point of view.

There are numerous cases where the Roma population tended to by these health mediators exceeds by far the number of people set forth in Order No. 619, making it virtually impossible to provide quality services. In reality, RHM can only tend to a subgroup of the assigned population, which they auto-select based on their own, potentially biased criteria of differentiation. When actually "entering" a community, RHM have little information available on the population they are about to serve – including the "geographic" assessment of the area of beneficiaries they are required to contact. Some 42 percent of RHM have stated that they tend to over 750 beneficiaries within their communities, whereas Order No. 619 clearly stipulates a maximum number of 500-750 persons per RHM.

Paradoxically, given the lack of any other mediation staff for Roma communities, the job description for RHM proves to be both limitative and, at the same time, too vast. There is an immediate need for staff to provide services to impoverished Roma populations and, for want of such staff, people turn to RHM for these services as well. RHM tasks could be limited to those elaborated in the job description only if extra staff were active within the community – such as social mediators, school mediators, community nurses, possibly even an "economic" mediator. In the absence of any such support, in reality, RHM are faced with intricate social, economic and medical on-site issues, spanning all age and gender categories.

The job description may be considered to be too vast or extended because, in an attempt to cover as many RHM tasks as possible, it turns into a genuine "license" to act in the community, where the sole guiding principle consists of the needs identified. Thus, it should be noted that, since it is complicated, the job description has not been completely described as yet – not even by RHM and RHM trainers. Certain tasks set forth in the job description are difficult to explain or to detail – for instance, it is hard to say to what extent a health mediator may advise the Roma on obtaining identity papers. Also, the responsibilities listed in the job description are not prioritized – in fact, RHM prioritize their own needs depending upon the emergency of the on-

site situations and based on more or less biased criteria. At this point in time, it can be noticed that different RHMs disagree on what are the most important tasks in the job description. One suggestion might be to structure the job description putting objectives in a certain priority order or to divide RHM tasks into stages (e.g. in the first six months, they should complete the census of the persons in the community – 700 persons – with no other tasks assigned).

In reality, the number of tasks the RHM resolves exceeds those set forth in the job description in all inspected communities, as the successful completion of activity requires on-site cases to be solved as well. It should be noted that all persons interviewed for the RHM position accept social care services as implicit in the RHM role. There have been no comments whatsoever indicating that they should stop providing these types of activities and stick to health services alone. Findings even show that RHM's social activities are better known than their health-related ones.

Nonetheless, 80 percent of RHMs believe there are no tasks that should be eliminated from the job description, while 66 of RHMs consider that the job description should not be supplemented with any additional tasks.

Practically speaking, Roma health mediators are the persons ready to help where needed, being the only interface between the Roma population and authorities in all aspects, not only health-related issues. It is notable that most persons in the Public Health Authorities, County Offices for Roma population and even family doctors consider that Roma health mediators cannot be substituted by any other staff (nurse, community nurse, therefore persons with a more solid medical background) – hinting at the fact that, during the cooperation, RHMs achieved a position that is clearly distinct from other medical trades, being different particularly through the social and interaction tasks of the mediator aspect. Another indication that it may be assumed that this profession is considered as distinct from other health professions is the reluctance of some medical staff to accept the RHM as a useful professional. Independently of the job description, which defines the RHM on a legislative level, the profession itself as it is perceived by the others implies two equally-important pillars: social tasks and health responsibilities, which are seen as being on a relatively equal footing in RHM activities.

There were cases when Roma health mediators lacked the required skills and background to carry out the tasks laid out in the job description: persons with communication difficulties, persons with interaction problems with the community or with family doctors, individuals insufficiently acknowledged and accepted by the community, persons with writing and reading difficulties.

5.2. Evaluating the RHM training program and assessing current equipment needs

Training

According to the job description, Roma health mediators are requested to perform a wide range of services and activities that require proper communication and interrelation skills, a proactive attitude and stamina, as well as an wide array of knowledge from various fields, such as health, psychology, sociology, Roma culture, legislation, human rights.

The current selection and training program raises certain problems. On the one hand, certain Roma health mediators are selected and even undergo the first training stage although lacking the required skills to carry out thier activities within the community with adequate results. Whilst on the other hand, RHM that do have the skills, qualities and willingness to improve professionally are not provided with the adequate framework. In other words, the current training system is a basic, minimal one, which fails to stimulate competitiveness and professional training.

With the exception of the initial RHM training course, there is no continuous training system and no compulsory training curriculum. Occasionally, Roma health mediators attend lectures and courses organized by Public Health Authorities and other institutions / organizations. Indeed, Roma health mediators are fully aware of this issue and have even acknowledged the need to develop their interpersonal communication skills such as their communication with other persons / authorities (family doctors, etc.). Some 23 percent of RHM consider that, given the responsibilities undertaken, their training level is poor or satisfactory, while the remaining 72 percent of RHM believe they have a good or very good training level.

The first training stage, which focuses on communication, although well-liked by participants, is far too short to develop proper communication skills in individuals lacking any previous skills or experience in managing conversation. In addition, although the trade is that of a *health* mediator, professional training does not provide access to sufficient medical information and knowledge. The current training system fails to ensure the basic medical knowledge that Roma health mediators need, nor does it provide information on social and legislative issues, other than Order 816/2002. In other words, the curriculum and the training system fail to coherently cover the key public health issues that Roma health mediators should then spread within the community. Most courses attended by RHM were organized by international organizations, such as JSI or Doctors of the World, and they were well-received by the trainees. Training courses are highly appreciated and they have a high impact – for instance, in the counties where JSI organized reproductive health and family planning courses, Roma health mediators acquired solid knowledge about RH, which was then communicated further to the population; this was clear from the RHM discourse and the results obtained within the community, namely increased access to and use of these services.

In the inspected counties, we failed to identify any real interest at the level of the Public Health Authorities for the medical training of Roma health mediators. The basic source of information of Roma health mediators is represented by their own reading of information materials / flyers / brochures. Considering these circumstances, one should praise the willingness and the tenacity

of some Roma health mediators in training themselves on various health issues, to be replicated further within the community.

The health topics that Roma health mediators would like to see addressed during training sessions include: counseling of persons suffering from chronic diseases, notions related to child diseases and counseling of physically- or mentally-impaired persons, each of these topics being voted by over 70 percent of RHMs. At the same time, Roma health mediators also need training in family planning and reproductive health, childcare and health, tuberculosis, immunizations and chronic diseases (diabetes, HTA).

Information on the legislative framework, human rights and social care are also extremely useful to Roma health mediators when tackling real social issues during their activity on site. Although the initial training course provides the basic information for understanding and enforcing the social security law, afterwards there is no clear-cut training system in this field. Even the Public Health Authority coordinators are poorly informed in this field and therefore cannot act as a resource for RHM.

Equipment

The RHM equipment needs are centered first and foremost around an office/headquarters where they can properly carry out their activity (only 36 percent have stated they have their own office/headquarters and only 14 percent have access to a computer). Thus, most Roma health mediators conduct their activity exclusively on site, regardless of weather conditions. There is no place where they can type their report or prepare their observation slips, where they can keep information on the beneficiaries. Roma health mediators therefore lack any facilities for recording information (such as computers or office supplies). Furthermore, beneficiaries can only contact mediators if they see them around or by calling them over the phone (64 percent of RHMs have a mobile phone, which is often their personal mobile phone, not the office one).

The existence of working premises for RHM would give them more confidence and make them more responsible, by providing a superior social and professional status.

There are also other important needs that must be met for the adequate implementation of the RHM activity, such as communication needs (mobile phones, telephone cards – as cited by 82 percent of responding RHMs), working gear (badges, rainwear jackets, umbrellas, rubber boots, etc. – 64 percent of respondents), traveling expenses (reimbursement of transport expenses – 55 percent of respondents). Moreover, some 74 percent of respondents consider that informative materials are required for raising awareness in the communities. At this point in time, only 17 percent of Roma health mediators have transport means available and only 34 percent have rainwear jackets and 7 percent have rubber boots.

Status

One of the obvious RHM needs is to acquire a new status, both professionally and socially. To this end, the existence of an office would act as an incentive, as a “promotion” from a social and professional point of view, an acknowledgement of the fact that society needs Roma health mediators. This would also bring their professional status in line with that of other civil servants, who have, by definition, a place to carry out their activity and to be found by beneficiaries.

Another major need of Roma health mediators is that of employment contracts of unlimited duration, which would considerably heighten the degree of certainty and safety for the future. One cannot talk about continuous professional training, about prioritizing tasks and structuring them in a well-planned manner in the long run while Roma health mediators are employed on a limited contract. On the other hand, this limitation is yet again reflected in the difference between the status of RHM and other civil servants, a gap likely to generate frustrations and even determine mediators to give up. The higher the level of RHM training and skills, the higher the degree of awareness with regard to these differences, as mediators analyze and weigh them. Remuneration is an equally important issue – Roma health mediators are relatively underpaid for their activity, they are not granted any bonus for on-site work, nor do they have any additional benefits.

There is also a need for an accurate evaluation, differentiation and remuneration mechanism for Roma health mediators, depending on each and everyone's achievements; this is also derived from the RHM recruitment, training, monitoring and evaluation system. After reaching a certain level, the lack of motivation for professional development may trigger dissatisfaction in certain mediators.

5.3. Assessing the actual RHM position in the interrelation with: Coordinators of the RHM program at the level of the Public Health Authorities (ASP), family doctors and program beneficiaries

5.3.1 The RHM – ASP coordinator relation

The relationship between Roma health mediators and the ASP coordinator is generally perceived by the Public Health Authority as a cooperation relation, wherein the involvement of both parties is of the essence. The basis of this cooperation relationship is mutual communication and exchange of information, which leads, in time, to better mutual knowledge and trust. The success of Roma health mediators' endeavors within the community hinges essentially on the level of ASP coordinator involvement in their day-to-day activities.

Given that the RHM professional status is often perceived as inferior, direct support from the ASP coordinator is fundamental. At a perceptual level, if the relationship is based on trust and support, it gives mediators a sense of belonging to the public health system, the feeling that they can turn to county authorities for support in case of problems related to public health or other matters.

However, in most of the inspected counties we have found that the ASP coordinator's actual involvement in the Roma health mediators' day-to-day activities is rather limited. Institutionally speaking, the ASP coordinator has a wider array of professional responsibilities and the interaction with RHM is relatively low during activities. The time allotted to the health mediator program often differs, depending on the actual workload and degree of involvement of the ASP coordinator. The involvement of ASP coordinators in the RHM training activities is perceived as being negligible, confirming the general problems related to RHM continuous training.

Respondents believe that a good cooperation relationship between the ASP and RHM is an essential requirement for a higher degree of involvement. However, stakeholders are not aware of the possibilities of deeper involvement in this program – and it also would appear that such possibilities are not included in the ASP coordinator's job description, as complicated as it is already.

From the part of the RHM side, there is generally a positive perception as regards the relationship with the ASP coordinator, a relationship which develops in time. Just as Roma health mediators facilitate the relationship with disadvantaged communities, the role of ASP coordinators is to continue to facilitate this relationship, through interaction and exchange of experience with Roma health mediators at county level and other public institutions involved in Roma matters; on a case by case basis, this facilitation may lead to further support for certain RHM endeavors at a central level. Moreover, ASP coordinators may facilitate RHM access to training courses, since they probably have access to relevant information and make the proper recommendations to ASP decision-makers. Some 84 percent of RHMs believe that their relationship with the ASP coordinator is good or very good.

One difficulty identified at the ASP level is the turnover in RHM coordinators, which generates discontinuity in the relationship with Roma health mediators and degree of uncertainty among them. In such cases, the cooperation relationship has to be built all over again, from scratch. In some cases, we have even found that RHM coordination was carried out by a different person than the one officially appointed for this purpose, thus reflecting the low level of interest on the part of the ASP management.

The main task acknowledged by ASP coordinators is the monitoring of RHM activity, by centralizing monthly activity reports and submitting them to the Public Health Ministry and to Romani CRISS. However, as previously mentioned, these reports seem to be rather formal and quantitative.

In general, the ASP coordinator does not conduct on-site visits, also due to the existing workload. Roma health mediators believe that it would be very useful if ASP coordinators took part in on-site visits; such visits would foster real contact with RHM activity and would provide Roma health mediators with a higher degree of authority with both local authorities and beneficiaries. This would also help strengthen the relationship with family doctors in the village/town and would lay the groundwork for an adequate qualitative assessment of RHM work.

Additionally, ASP coordinators do not organize training courses on medical issues, which are not always easy to hold at county level. There have been cases where ASP coordinators considered that their tasks under this program were limited strictly to collecting RHM monthly activity reports and redirecting the relevant information.

5.3.2. The RHM-FD relationship

The relationship with family doctors (FD) is good in most cases, with teams forming throughout the country. Family doctors are seen as the most important RHM collaborators in relation to target communities. Some 94 percent of family doctors that filled out the

questionnaires under the qualitative component of evaluation believe that their cooperation with Roma health mediators is good or very good, by defining it as a "cooperation" relationship rather than subordination. Some 95 percent of RHMs consider that this cooperation is good or very good, while 97 percent of RHMs are of the same opinion as family doctors that this is a "cooperation" rather than subordinate relationship. However, certain tensions or conflicts between family doctors and Roma health mediators have been reported locally.

The success in building a good relationship between family doctors and Roma health mediators is inextricably linked to the perceived contribution to results obtained by FD cabinets. The more useful the contribution of Roma health mediators to FD activities, while also observing the professional "hierarchy", the better the relationship between the two parties. Family doctors consider RHM activity extremely useful to them, as it facilitates regular contact with various target communities and streamlines their on-site visits. Such facilitation is also extremely useful when it comes to several delicate responsibilities in relation to the Roma population, namely immunization and contraception – particularly within more traditional communities.

Sometimes there is a misunderstanding of roles; for instance, there are certain family doctors who think that Roma health mediators are directly subordinated to them; such cases require ASP intervention, in order to clarify that RHMs are monitored and coordinated at ASP level.

As RHM both belonging to the Roma community and are emotionally invested in solving the issues of these communities, there is often a concern that numerous persons that do not have medical insurance are included on FD lists. However, this is contrary to current registration procedures with family doctors and to FD's access to financing. For such persons, RHMs conduct other activities for acquiring the status of an insured party, so that they might be included on current FD lists.

Family doctors are perceived as important collaborators in relation to target communities, although RHMs also cooperate directly with other physicians, particularly pediatricians.

Generally speaking, one could say that the relationship with family doctors evolves through several stages. In the initial stage of the cooperation, the relationship is usually cold, when family doctors evaluate Roma health mediators. Family doctors are somewhat inquisitive, both curious and reluctant to start this cooperation, which they nevertheless accept because it emerges as a potential help that is free-of-charge. Such a situation occurs most often due to lack of information – direct responsibility for this lies with the Public Health Authority, as supervisor and coordinator of the RHM activity.

The way in which Roma health mediators interact with family doctors and their personal communication skills are key determinants of the personal dimension of the relationship between the two parties. It should be highlighted that the relationship between the two parties has the potential to represent a very good team, in which the professional and the personal dimensions mingle.

It should also be noted that, often, family doctors are not properly informed by the authorities regarding the RHM role at a local level. For this reason, Roma health mediators may be initially regarded with indifference or suspicion by family doctors or nurses, yet so far there have been no reports of rejected cooperation or discrimination against RHMs by family doctors.

During the initial stage, nurses usually regard Roma health mediators as a "rival" competing for their position within the cabinet – especially older nurses. In the beginning, the two persons are not on an equal footing – doctors consider themselves to be hierarchically superior to RHMs and do not even try to conceal this. This is also the stage when family doctors require Roma health mediators to perform all sorts of activities that are not directly related to their job description.

The second stage is when Roma health mediators prove their "usefulness" to family doctors. This usually occurs by solving some of the most difficult issues doctors are faced with: RHMs take charge of "on-site" activities, by bringing the Roma population in for immunization, identifying and bringing in any persons from the Roma community with major health problems. This usually occurs against a general background of increased access to and use of medical services by the Roma population. It is also the time when RHM involvement leads to the early identification and prevention of certain diseases. A solid medical training would definitely contribute even more to disease prevention, which is all the more important for contagious diseases.

Another important issue for doctors is increasing the number of insured patients on their lists. To this end, Roma health mediators have a direct contribution to obtaining identity papers and acquiring the insured party status for some of the Roma who previously resorted to their services without health insurance. These results relieve family doctors of some burdens and support them in their activity in a way in which no other medical staff could have done. As a result, family doctors come to highly appreciate the support given and their relationship with Roma health mediators strengthens and transforms into one of cooperation rather than subordination.

It is worth noting that there are clear differences, relating to both status and interaction, between doctors and nurses, on the one hand, and doctors and Roma health mediators, on the other. There is a clear subordination relationship between family doctors and nurses, both professionally and financially, even though the relation may be a friendly one, while Roma health mediators enjoy a higher degree of independence and autonomy in relation to family doctors (financial autonomy included). As the relationship progresses, family doctors also support the RHM activity, thus enhancing the latter's credibility within the community.

The third stage is when the cooperation relationship between family doctors and Roma health mediators sets in, which is usually a very good professional relationship. This stage commences when family doctors realize that it would be a heavy blow if Roma health mediators just quit, and thus they would be willing to identify solutions for enhancing the latter's degree of comfort / stability or even their financial resources. The premise of mutual need and support balances the ratio of powers between the two stakeholders, generating a balanced cooperation relationship, wherein family doctors no longer feel the need to declare or impose a hierarchically superior position. The cooperation with nurses is also very good during this stage, as nurses understand the RHM role and the fact that – given their profession and background – Roma health mediators do not constitute a professional threat, but rather provide support.

There have been cases on site when the RHM activity did not necessarily yield positive results for the FD cabinet (i.e. the access to and use of health services did not increase), which leads to strictly formal relations between family doctors and Roma health mediators. In this case, the RHM – FD relationship is limited to the latter endorsing the activity reports submitted by Roma health mediators. There have also been isolated cases when Roma health mediators generated conflicts between the Roma population and family doctors, which gave birth to a tense relationship between RHM and FD. There was one situation when a family doctor that specifically requested cooperation with a certain RHM was subsequently dissatisfied with the latter's activity. In these cases, the initial cooperation stages could not be completed and family doctors did not accept Roma health mediators as collaborators. If the RHM activity fails to increase access to and use of FD facilities, the efficiency of their activity becomes questionable (from a both quantitative and particularly qualitative point of view).

5.3.3. The RHM-Beneficiaries relationship

The relationship between RHM and the community is generally good or very good. Some 89 percent of the family doctors interviewed under the quantitative component of the study consider the cooperation between RHMs and the Roma ethnics in the relevant communities as being good and very good, with 91 percent of FD satisfied and very satisfied with the RHM activity in relation to the needs of the Roma community. No less than 93 percent of RHMs believe that their cooperation with beneficiaries at community level is good or very good.

Overall, the relationship between RHMs and communities / direct beneficiaries is considered by all stakeholders / respondents under the quantitative component of the study as being good or very good. After all, the key to a successful relation with the beneficiaries is the level and quality of RHM acceptance by the communities. In this sense, the decisive element is the mediator's communication skills, as well as their persuasion ability and extent to which they are appreciated by the community (in fact, the same qualities are also essential in the selection stage of future RHMs). The first contacts with the community and especially their acceptance by opinion leaders within the community are extremely important. Once Roma health mediators have been accepted by the community and have shown their commitment and involvement through arduous work, beneficiaries gradually learn to appreciate the RHM presence in their community.

Among the variables in outlining the profile of the RHM – direct beneficiaries relationship, the most important ones identified to date are:

- **Roma health mediators' innate communication and interrelation skills**. This is an essential element in building the relationship with the community. The mediator should know how to interact with the respective community members, and have the capacity to identify and interact with opinion leaders within the community. Mediators' communication skills are usually innate and improved with practice. Subsequent training on communication and mediation matters is less important than this innate skill. We have identified extremely active and efficient mediators in their relation with the community, with good interaction skills, but also mediators that were unable to observe the same high standards in their activity due to certain communication deficiencies.

Furthermore, it is vital for RHMs to be of Roma ethnic origin and to be familiar with the language spoken within the community. There is also information on the existence of distinct customs among various Roma families, which may induce significant differences as regards the way in which Roma health mediators should integrate and communicate with the community. This type of information could prove extremely useful in training RHMs, prior to their first contact with the community, in order to avoid personal rejection and even rejection of the program by certain communities.

- **RHM belonging to the community.** The survey identified both RHMs belonging to the community where they worked and RHMs living in a different community and traveling to work on a daily basis. The benefits of Roma health mediators belonging to the communities where they work include: closeness to the community, easier acceptance in some cases of their mediation and education activities, better knowledge of community customs, traditions and problems. On the other hand, RHMs will inevitably relate differently to various community members, while the latter will also cooperate differently with them, depending on family relations, kinship or friendship / aversion towards their family. Another drawback of belonging to the community is that deeply committed Roma health mediators will be overwhelmed by the volume of work, since beneficiaries will come directly to their home to request their services, regardless of the hour or time schedule.
- **Type of community – traditional vs. assimilated (non-traditional).** In this sense, it goes without saying that RHMs operating within traditional Roma communities have a far more difficult task than those carrying out their activity in non-traditional communities. In the case of traditional communities, the RHM activity is hampered by specific habits, shyness in the community and the influence of different statuses within the family. These aspects call for a much more in-depth exploration, in order to identity adequate solutions and proper education methods for information to penetrate this type of closed community, as well as for an analysis of the specific characteristics of health mediation activity within distinct Roma families.
- **The number and importance of cases solved by mediators, especially at the beginning of their relationship with the community.** Just as in the RHM – FD relationship, mediators also have to prove their usefulness in relation to the community. The cases solved by them, which otherwise would have been left unresolved, become success stories told within the community, thus laying the groundwork for a long-term relationship with community members. It has been noticed that success stories are more commonly related to the solving of social issues (such as children placed in foster care, obtaining identity papers or social aids) than medical ones.
- **Different beneficiary needs** (social, identity, economic, medical, etc.). The interaction between RHMs and various beneficiaries within the same community is usually different, depending on personal relationships, the ease of interaction and the different needs identified by RHMs at beneficiary level. Interaction also differs depending on the RHMs' commitment to solving a variety of different issues and their availability in so doing.

- **The size of the communities covered by Roma health mediators – having a** very large community to cover may act as a barrier to the RHM in establishing a good relationship with beneficiaries. Moreover, this context calls for a subjective selection by the RHM of a subgroup to be better covered – given that, many a time, the community covered by a RHM is vaguely defined.

Overall, it has been noticed that, in general, direct beneficiaries do not fully understand the RHM role within the community. These direct beneficiaries fail to understand the formal segregation of professional roles, as they do not make a clear distinction between the multitude of issues presented to Roma health mediators. Thus, in many cases, beneficiaries tend to request services or information that are not related to the RHM's scope of activity. We have identified situations where RHMs are considered by the community as nurses or even doctors, as beneficiaries turn to them for medical services. At other times, beneficiaries want to see other economic or social issues solved, which are considered at least as important as medical ones, believing that Roma health mediators have the power to solve such matters. Compared to beneficiaries within the community, Roma health mediators have a more solid background and better interaction capacity with the authorities. Given their perceived superiority, Roma health mediators are often vested with powers and tasks well beyond realistic expectations. However, this position also confers on them a certain status of "authority", of a "leader", increasing the likelihood that beneficiaries will listen to them and follow their advice. This status also gives Roma health mediators a higher degree of professional and personal satisfaction, acting as a major incentive to continue their activity, despite various problems or dissatisfaction, such as a lack of acknowledge of their professional status from the authorities. On the other hand, being vested with powers and tasks going well beyond realistic expectations can lead to an unmanageable workload.

This final situation highlights a fundamental problem in calibrating the professional tasks of Roma health mediators as they are currently defined in Romania. A possible solution to this issue is to examine how the professional tasks of these community workers are calibrated in several countries in Western Europe, where they are defined as cultural mediators (mingling health mediation with educational, social, cultural mediation, etc.).

5.4. Evaluating RHM contribution to ensuring access of the impoverished population within Roma communities to health services in general and to reproductive health services in particular.

Undoubtedly, the RHM activity enhances Roma patients' access to and use of medical services in general and reproductive health and family planning in particular (e.g. the number of Roma patients enrolled on family doctors' lists has risen after acquiring insured status, the immunization rate has increased, as well as the number of users of contraceptive methods, while the number of abortions has dropped). One could safely assume that RHMs are currently the most important driving force in spreading information and educating the Roma population, as well as in creating the necessary environment for a trust-based relationship between Roma patients and health service providers.

Estimates show that over 8,000 Roma persons have been supported by Roma health mediators in enrolling on family doctors' lists since the start of the Health Mediators Program within Roma Communities in Romania. Based on the same estimates, more than 7,300 Roma persons have still to be registered with family doctors, in the communities where RHMs are currently active.

Interviews with direct beneficiaries have shown that RHMs constitute the main source of information on reproductive health and family planning services, such as using modern contraception methods, the correct use of condoms and STI prevention.

It became obvious that, at least during the early stages of the RHM activity within the community, the effectiveness of their work was to a large extent due to their commitment and persistence, which extended to actually accompanying patients to the medical cabinet.

As far as reproductive health and family planning services are concerned, the progress made so far through RHM involvement shows that success is within reach only if proper consideration is taken of the delicate issues and shyness of individuals within the Roma population, realizing that barriers can be overcome gradually, with tact, by mobilizing women in particular, who can then act as vectors spreading knowledge and attitudes within the community. Subsequently, during step two, it is almost mandatory that contraceptives be free of charge in order for the population to have easy access to them.

Furthermore, as regards reproductive health and family planning services, there have been indications that the JSI training program in particular proved extremely useful, highlighting the need for it to be replicated during upcoming training sessions.

Finally, as an overall conclusion stemming from the entire research sequence, it should be noted that RHM contribution to ensuring access of the impoverished population within Roma communities to health services in general and to reproductive health services in particular hinges on numerous interdependencies existing between health issues, on the one hand, and social, economic, educational and cultural issues, on the other, which are not their direct tasks.

5.5. Assessing the quality of the current RHM program monitoring and evaluation system

The reporting system currently employed for assessing RHM activity is quantitative in nature, without any qualitative elements. This type of reporting consists of the filling out by Roma health mediators of a monthly activity form (number of pregnant women monitored, number of children brought in for immunization, etc.), duly endorsed by the family doctor and submitted to the ASP coordinator. Afterwards, the information centralized by the coordinator is forwarded to the Health Ministry and to Romani CRISS. ASP coordinators do not receive any feedback from the institutions to which these reports are submitted.

Although the main advantage of this reporting system is its simplicity, it also has the following drawbacks:

- it appears to be merely a formal procedure that has to be "checked" – Roma health mediators are not held accountable for filling out the report. It is difficult to retain the exact number of beneficiaries with a certain problem solved in a certain month. Consequently, the accuracy of the collected data is low, and approximations may range from small to extremely large. One cannot be held responsible for a task perceived from the very beginning as difficult to complete in an accurate manner. As a result, the level of involvement and RHM responsibility in the reporting activity are relatively low.

- it depicts only a partial image of the RHM activity. The RHM activity is complex, and the solving of certain situations requires a longer time. Hence, whilst there is no record of the degree of difficulty of each case, the number of cases solved can only serve as a partial indicator of activity. Additionally, the assessment does not relate to any identified RHM monthly "workload" – therefore we lack an efficiency indicator, which would allow us to compare the collected data. A control system for the validity of data provided by the RHM in the evaluation form is also missing – the theoretic supervision carried out by family doctors and ASP is, in fact, quite superficial, for both objective and subjective reasons.

- it does not allow the actual evaluation and comparison of the activity performed by various Roma health mediators, which is a demotivating factor for persons committed to their work.

- Roma health mediators do not receive any feedback from ASP coordinators or from family doctors. Their primary feedback is the community itself, ensuring that they continue to tailor their work to the beneficiaries' needs. In fact, Roma health mediators represent a genuine bridge between the Roma community and the state system / authorities, a go-between position that implies a dual referential. In other words, the assessment of the health mediator's activity is different if conducted from the employer's perspective (Ministry of Public Health), which has an established public health policy and, by paying certain people, wishes to obtain certain results (immunizations etc.), compared to an analysis of the same activity from the perspective of community needs. Since there is no other mediation staff available for Roma communities and the monitoring and evaluation system by the ASP coordinator is reduced in terms of interventions, RHMs taylor their activities to pressures at the community level, which are both social and medical, rather than to their employer's public health needs.

In some Public Health Authorities, in addition to the quantitative reports, Roma health mediators also submit qualitative reports to the ASP coordinator (studies endorsed by the

family doctor or the local authority representative). The impact of this on the RHM, as observed by the ASP coordinator, was an increased degree of accountability; at the same time, the groundwork was laid for discussions on the quality of the activity carried out by the Roma health mediator.

Against this backdrop, the RHM Activity Monitoring and Training Regional Centers (implemented by Romani CRISS) constitute a much awaited and highly appreciated initiative, particularly by persons involved in supporting this program and by more experienced mediators, who look forward to a genuine monitoring, evaluation and motivational system. The centers are located in Giurgiu, Cluj, Gorj, Bucharest, Vaslui, Covasna and were established in October 2006.

6. OVERALL CONCLUSIONS

- The RHM terms of reference only partially reflect the Roma health mediator's day-to-day activity., Although most of the activity is in line with the job description, beneficiaries turn to Roma health mediators for help in solving much more complex and diverse issues than those established as direct tasks, particularly social issues.
- Initial training courses provide basic knowledge of legislation and communication, yet they are insufficient and too short to be able to shape up genuine communication and mediation skills. Moreover, the current training system fails to ensure the basic medical knowledge that Roma health mediators need, nor does it provide information on social and legislative issues, other than those established in Order 816/2002. There is no continuous training system or compulsory training curriculum, although the RHM training needs are real, important and publicly stated. Occasionally, Roma health mediators attend courses organized by Public Health Authorities or other institutions / organizations. The activity of the Roma health mediator should be coordinated with that of the community nurse, in communities where they both exist, as well as with the activity of social workers employed by the Mayor's Offices. In addition, large communities should have more than one RHM, as a single Roma health mediator is unable to cope with the real needs of the community.
- The RHM equipment needs are centered first and foremost around an office/headquarters where they can properly carry out their activity; there are also other important equipment needs to ensure the adequate implementation of the RHM activity, such as communication needs (mobile phones, telephone cards), working gear (badges, rainwear jackets, umbrellas, rubber boots, etc.) and travel expenses.
- One of the most important identified RHM needs is that related to their "status", namely acquiring an acknowledged and stable social and professional status, also including the fair evaluation of each RHM's activity.
- The relationship between the RHM and the ASP coordinator is generally one of cooperation of a reactive type on the part of the ASP coordinator (who usually responds positively to RHM requests) and not so much a relation based on involvement and active support.
- The relationship with family doctors is generally good, with teams established on site. However, local conflicts or tensions have been reported.
- The relationship with beneficiaries is good, depending highly on the type of community and the compatibility between the RHM culture and that of the Roma families to whom they address; the RHM's communication and negotiation skills also play an essential role.
- Roma health mediators are currently the most important driving force in spreading information and educating the Roma population. The RHM activity enhances Roma people' access to and use of medical services in general and reproductive health and family planning in particular (e.g. the number of Roma patients enrolled on family doctors' lists has risen after acquiring health insurance, the immunization rate has

increased, as well as the number of users of contraceptive methods, while the number of abortions has dropped).

- The reporting system currently employed for assessing RHM activities is quantitative in nature, without any qualitative elements. Thus, Roma health mediators are not held accountable for completing the report, which only depicts a partial image of RHM activities. It does not allow the actual evaluation and comparison of the activity performed by various Roma health mediators and RHMs do not receive any feedback from the ASP coordinator or from family doctors.
- The RHM Activity Monitoring and Training Regional Centers (implemented by Romani CRISS) constitute a much awaited and highly appreciated initiative.

7. SWOT ANALYSIS AND APPLICATIVE RECOMMENDATIONS FOR DESIGNING THE UPCOMING ACTIVITIES WITHIN THE RHM PROGRAM AND INTEGRATED MEDICAL AND SOCIAL SERVICES WITHIN ROMA COMMUNITIES

7.1. SWOT ANALYSIS

Strong points:

- High penetrability of information across Roma communities, with outstanding results, visible both socially and medically.
- The existence of extremely well-trained RHMs, capable of training other Roma health mediators, committed to their community activities.
- The existence of ASP coordinators and family doctors who understand and support the Health Mediators Program within Roma communities.

Weak points:

- Recruitment and selection: some RHMs lack the required communication and mediation skills.
- The current monitoring system is faulty and generates inequalities among Roma health mediators.
- Insufficient training.
- Complex social issues that RHMs address, to the detriment of their "medical" activity and not necessarily included in their job description (shortage of staff to take care of these issues).
- Insufficient staff assigned to large communities.
- ASP coordinators and family doctors who get involved only formally in implementing the RHM program.

Opportunities:

- Establishing community-level teams consisting of Roma health mediators, community nurses and family doctors.
- Transferring the RHM program from the mother and childcare national program to the community assistance national program and amending the job description and the training strategy, following the pattern of those for community nurses, culturally tailored for RHMs.
- Setting up and activating / involving the inter-departmental commission within the Public Health Ministry, including ASP coordinators supporting this program.
- Creation of the five regional monitoring centers, for better monitoring of RHM activity and enhancing the quality of services.

Challenges:

- Transferring Roma health mediators from Public Health Authorities to the local Mayor's Office.
- Relative lack of involvement / support from the authorities.
- Lack of financial incentives for RHMs, lack of a well-defined status, lack of motivation for professional enhancement.

7. 2. RECOMMENDATIONS

These recommendations based on data analyzed in this study are based on the clear-cut premise that the Health Mediators Program within Roma communities in Romania is efficient, having a real impact on the health condition of the Roma population in the target communities. The recommendations cover sustainability issues and ways in which the program should be continued and improved.

7.2.1. For public administration structures at a central / local level:

o Discussing the RHM situation within the Working Group for Roma Public Policies – the central structure in charge of monitoring and evaluating the *Romanian Government's Strategy for Improving Roma Living Standards.*

o Setting up, under the coordination of the Ministry Commission for Roma within the Ministry of Public Health, a working group that consists of representatives from the Ministry of Public Health, the Ministry of Public Administration and the Interior, Public Health Authorities, the National Agency for the Roma, family doctors, health mediator groups etc., in order to review the basic documents underlying RHM activities and promote legislation reflecting the complexity and the importance of health mediators' work.

o Debating the relevant issues in connection to RHM activities in the Ministry Commission for Roma within the Ministry of Public Health and proposing specific changes advocating the maintenance of RHMs in local public health structures and a higher number of RHMs for materially-impaired communities.

o Correlating the RHM program with the national community healthcare program, given the complementary nature of the two programs, and the actual support which the latter – through community nurses – could provide to Roma health mediators, particularly in large-size communities.

o Discussing the relevant RHM elements in the decentralization strategy proposed by the Ministry of Public Health, so that budgetary allocations might directly support RHM activities and allow an increase in their number within disadvantaged communities, without the possibility of reallocating the funds for other purposes (conditional allocation).

o Institutionalizing the health mediator profession and identifying any possibilities for Roma health mediators to be employed on a permanent basis, as well as possibilities of a higher financial remuneration.

o Close cooperation between the National Employment Agency and the competent structures within the Ministry of Public Health for preparing an occupational standard, a training curriculum and qualification courses rewarded with diplomas acknowledged in the labor market, as well as for drawing up professional training standards.

o Reviewing the tasks laid down in the RHM job description, based on current regulations and the realities within the target communities.

o Evaluating, at the level of the above-mentioned working group, the job descriptions of other professional categories in charge of medical and social issues within the target communities, for a better collaboration with RHM activities.

o Ensuring the minimum equipment standards for carrying out RHM activities: office premises, working gear and logistics (phone communication, travel means, office supplies).

o Implementing groundbreaking changes in the RHM recruitment and training system, in line with their job description – so as to include the development of communication skills, medical, social, legislative and human rights knowledge, as well as involving the ASP coordinator in this recruitment process.

o Developing a set of community selection criteria and drawing up a map of target communities requiring the presence of RHMs; estimating personnel needs for the upcoming years; raising the minimum education standard for becoming a Roma health mediator and developing a training system similar to other trades, even starting from high-school.

o Improving the RHM activity monitoring and evaluation system, to cover both quantitative and qualitative aspects. Correlating this system to FD activity evaluation systems and identifying specific mechanisms for motivating family doctors to cooperate with RHMs.

o Preparing a schedule of regular meetings for coordinating regional activities and exchange of experience, with the involvement of local and regional decision-makers and the participation of RHM representative structures.

7.2.2 For representatives of Roma NGOs and other interested organizations from civil society:

o Consulting the decentralization strategy proposed by the Ministry of Public Health and advocating changes to support RHM activities and increase their number within disadvantaged communities.

o Identifying within the local communities any persons with the capacity to become RHMs and supporting their promotion to ASP level, for further training and employment.

7.2.3. For health mediators:

o Ensuring RHM maintain a permanent desire for broadening their knowledge base and their professional skills.

o Ensuring permanent cooperation between RHMs and the structures at county level for implementing the Romanian Government's Strategy for Improving Roma Living Standards (Joint Committee, County Offices for the Roma, local experts on Roma matters, etc.)

o Maintaining permanent cooperation with Roma NGOs active at local or county level.

o Establishing a structure for representing and promoting the RHM profession, similar to that for nurses or doctors. Establishing communication networks with the representative structures of the above-mentioned trades; preparing a deontological code of the health mediator profession as well as a health mediator visibility strategy.

8. ANNEXES

8.1 CASE STUDIES ON HEALTH MEDIATORS' TASKS WITHIN ROMA COMMUNITIES

CASE STUDY – SOLVING A SOCIAL ISSUE

L.E., 65 years old

Member of the Budacu de Jos community, which consists of 4 villages (Budacu de Jos, Jena, Simioneşti, Buduş), 15 km from Bistrița, on a paved road with easy access. The community is connected to the city by bus (two per day). The community has approximately 4,000 members, half of them being of Roma ethnicity.
The selected person lives within the Roma community, in a house with minimum living conditions. Available utilities: fountain water. The house is relatively clean and well-maintained. She lives together with her granddaughter, aged 13. Her only income source is the retirement benefit amounting to RON 47.

Case: at the grandmother's request, the Roma health mediator helped take L.E.'s granddaughter from foster care back into the care of the family; the RHM helped her to access the child maintenance income worth RON 80, which, together with the maternal benefit worth RON 50 allowed the grandmother to look after the child.

The granddaughter that was placed in foster care is the only daughter of L.E.'s son – deceased; the mother abandoned the child. Practically, for want of support from the RHM, the grandmother would have been unable to raise the child by herself, lacking the required resources to do so. Thus, the Roma health mediator was the only person who became involved from the very beginning until the very end in solving this case – reuniting a family.

The relevant task in the terms of reference:
s). *signals to the social worker any potential cases of child abandonment (being familiar with the situation of families within the community, the health mediator is aware of the intentions of desperate, impoverished families to abandon their children in institutions).*

CASE STUDY – SOLVING A MEDICAL AND SOCIAL ISSUE

A, 33 years old

Member of the Radu Negru community (Brăila city), consisting of approximately 500 traditional people of Roma ethnicity. The selected person lives within the Roma community, in a dilapidated house with four rooms hosting 12 individuals. They have no running water because they have no money to pay for it and they take water from the sewer. A. is 33 and has 9 children.

Case**:** The A. family is extremely poor. Data collected by the ASP coordinator, the Roma health mediator and the family doctor a year ago indicate that the family situation is truly desperate. None of the family members had a stable workplace, none of the children went to school, they had no identity papers and were not enrolled on the family doctor list.

The Roma health mediator took all necessary steps to obtain identity papers and children's birth certificates, and facilitating their registration on FD lists. After several house calls, the Roma health mediator managed to inform A. about family planning services and persuaded her to come to the FP cabinet within the maternity.

The RHM insists that the family no longer send their children out on the streets to beg or steal and persuades them to go to school instead. "The mediator has helped me, she took my children to school and rid them of lice".

The RHM is currently visiting the A. family almost weekly, reminding them to take their children to school, to wash up, she brings children in for immunization and tells them of health issues in general.

The relevant task in the terms of reference:
d) explains the basic notions and the advantages of family planning, by including them in the traditional cultural system of the Roma community;
j) explains the advantages of including persons in the health insurance system as well as the procedures to obtain health insurance;
k) explains the advantages of personal hygiene, of common lodgings and premises; raises the community's awareness of hygiene measures ordered by the competent authorities;

CASE STUDY – SOLVING A MEDICAL AND SOCIAL ISSUE

R, 30 years old, single. HIV infected following a blood transfusion.

Case**:** A new member of the community, R. is regarded with suspicion by the other community members. When they find out that R. is HIV positive, they want to force him out of the building and he is one step away from being lynched.

The Roma health mediator finds out about this delicate situation and goes on site to discuss with R.'s neighbors. She goes to the Public Health Authority to request some fliers and brochures on HIV infection, which she then disseminates within the community. When handing out the brochures, she informs the population about the ways in which HIV is transmitted, persuading them that R. does not constitute any danger to his peers, and therefore he should be accepted in the community.

The relevant task in the terms of reference:

*m) mobilizes and accompanies community members in relation to public health actions (immunization campaigns, **information and education campaigns for raising awareness on health issues,** actions meant to identify chronic diseases, etc.); explains their role and purpose;*

CASE STUDY – INCREASING ACCESS TO AND USE OF FAMILY PLANNING SERVICES THROUGH COMPETENT INFORMATION

S.L., 21 years old

Member of the Săcele community, consisting of 12,000 Roma ethnics, near Braşov, on a paved road with easy access, connected to Braşov by buses. The selected person lives

within the Roma community, on a secondary, narrow street which is unpaved and hence difficult to reach in times of rain / frost. Precarious living conditions. Available utilities: electricity, water.

Case: The Roma health mediator has informed the woman of contraception methods and has recommended that she visit the FP cabinet; the respondent is currently using contraceptives.

S., aged 21, has 3 children. Four years ago, after giving birth to her third child, she decided to use the intrauterine contraceptive device as a contraceptive method. Nine months ago, she wanted to give up the intrauterine contraceptive device and hence contraception as a whole, considering that it affects her health. Following the counseling services provided by the Roma health mediator, it was discovered that she does not want any more babies. During meetings, the RHM explained to her what contraceptive methods are available and the advantages of using them, by referring her to a family planning cabinet. Following the visit to the FP cabinet, the respondent is currently using contraceptive methods again, having made an informed decision, based on knowledge of the benefits and drawbacks of the method employed.

The relevant task in the terms of reference:
d) *explains the basic notions and the advantages of family planning, by including them in the traditional cultural system of the Roma community.*

CASE STUDY – SOLVING A SOCIAL ISSUE WITHIN THE COMMUNITY

F., 30 years old

Member of the "Doi Moldoveni" community (Călăraşi city), consisting of approximately 12,000 persons of Roma ethnicity, in the vicinity of the Călăraşi County Hospital. The selected person lives within the Roma community, in an apartment building without heat or electricity. The living conditions are precarious and the family has an extremely low income (the husband is a day-worker, another income source is the children's allowance). Available utilities: electricity and water. F. is 30 years old and has 3 children. She suffers from a serious chronic disease.

Case**:** RHM noticed that the family's one-year old baby could not even sit upright at this age. Moreover, the Roma health mediator realized that the woman was unable to take proper care of the baby and that the latter was in danger of starving. The Roma health mediator informed the woman about the baby's condition. Together with the father, they reached the conclusion that it would be best for everyone to have the baby taken to hospital and then placed in foster care.

Once the woman accepted, the Roma health mediator called the Călăraşi Child Protection Department, which initiated a social study the following day. Following the study, the child is in intensive care at the County Hospital so that his general condition might improve (he has been diagnosed with anemia and malnutrition); upon release from hospital, the baby will be taken to a placement center.

The relevant task in the terms of reference:
f) *explains the basic notions and the importance of child medical care;*
g) promotes a healthy diet, especially among children, as well as breastfeeding;

s) signals to the social worker any potential cases of child abandonment (being familiar with the situation of families within the community, the health mediator is aware of the intentions of desperate, impoverished families to abandon their children in institutions. Such situations can be prevented if the qualified bodies are notified in due time).

CASE STUDY – SOLVING A SOCIAL ISSUE WITHIN THE COMMUNITY

A, 30 years old

Lives in Craiova, within a Roma community on the outskirts of the city. The lodging is close to the main road and has access to various public transport means. The Roma community comprises some 10,000 members. Available utilities: electricity, cold and hot water. The house is clean and well-maintained. She lives with seven other family members. A. works at a store in Craiova, while her husband works in Spain.

Case: The Roma health mediator helped obtain the birth certificate for A.'s youngest child, aged 6.

Six years and a half ago, A. found a job in Spain. Whilst there, she realized that she was pregnant and, four months later, she gave birth in a Spanish maternity. Once discharged, the only paper they handed her was a release certificate bearing the names of the child and of the parents. Upon return to Romania, A. had several unsuccessful attempts at obtaining a birth certificate for the child. In 2005, A. found out from a cousin that there is a person who can help her: the mediator.

After talking to A., the mediator became involved in solving this issue. After several meetings with representatives of the County Office for the Roma and employees of the Mayor's Office and of the Prefect's Office, she managed to obtain a birth certificate for A's child.

A. decided to apply for a mediator position in Craiova, so that she might also provide support to other community members.

Task fulfilled (not included in the terms of reference):
- *facilitating social inclusion (obtaining identity papers)*

CASE STUDY – SOLVING A MEDICAL ISSUE

L., 15 years old

Lives in Timişoara, within a Roma community on the outskirts of the city; has access to various public transport means. The Roma community comprises some 5,000 members. The selected person lives in a house with decent living conditions. Available utilities: electricity, heating, cold and hot water. The house is clean and well-maintained. L. is currently at the Timişoara County Hospital, with a very serious diagnosis requiring surgery.

Case: The Roma health mediator helped diagnose and commit L. to the hospital. Her parents are not very familiar with Romanian, let alone medical terms. The mediator's presence was necessary, as the doctor explained the girl's problem to her and then she explained to the parents how serious things were.

One year ago, L. started having severe digestive symptoms. Before turning to the health mediator, no one knew what was wrong with the girl. When the mediator found out, she took the girl to see the family doctor, who referred them to a specialist. The diagnosis requires surgery for her to survive. Since the girl's parents are not very familiar with Romanian, the mediator had the difficult task of explaining the situation to them.
Note: before showing up for the interview, the mediator went to see the girl at the hospital.

The relevant task in the terms of reference:

b) *facilitates communication between community members and the medical staff;*

CASE STUDY – SOLVING A MEDICAL ISSUE WITHIN THE COMMUNITY

E., 34 years old

A member of the Roma community in the commune of Puşcaşi, located 10 km away from the city of Vaslui, a community consisting of approximately 700 persons of Roma ethnicity. She lives in the community, in a lodging consisting of two rooms hosting 6 persons. E. is 33 and has 4 children.

Case: A few years ago, E.'s husband was diagnosed with tuberculosis. He started the treatment twice, but he stopped each time. Last year, two of the children were diagnosed bK positive.

The family doctor turned to the Roma health mediator who pays several visits to the E. family in order to explain to them the risks related to tuberculosis and failure to comply with proper treatment. At the mediator's request, the husband agreed to start a new treatment. The mediator visited the E. family on a weekly basis and monitored the course of the treatment. The three members of the E. family diagnosed with tuberculosis are now following the prescribed treatment and are currently deemed cured.

The relevant task in the terms of reference:

o). *at the request of the medical staff and under their strict supervision, explains the role of the medicine treatment prescribed, the possible adverse reactions and monitors the way in which medicines are taken (e.g. the strictly monitored treatment of the patient suffering from tuberculosis);*

CASE STUDY – SOLVING A SOCIAL ISSUE

M, 26 years old

A member of the Roma community in the commune of Puşcaşi, located 10 km away from the city of Vaslui, a community consisting of approximately 700 persons of Roma ethnicity. M. lives in the community together with her husband and their four children. The husband has been unemployed for several years now; he sells scrap iron for a living. Their house also hosts M.'s three sisters and their husbands.

Case: M. has a precarious situation, money is insufficient, often at times they don't have anything to eat. Although she doesn't want any more babies, M. is not using any modern contraceptive method. Last year she was pregnant twice, yet both resulted in miscarriages.

The Roma health mediator presented M.'s case to the social worker. Following the social study, the family will be the beneficiary of social aid. Moreover, the RHM informed M. about contraception methods. Although to begin with, the husband did not agree to using contraception, the mediator explained to him the risks M. faced if she got pregnant one more time, as well as the potential hardships of having a fifth child.

The relevant task in the terms of reference:

d) *explains the basic notions and the advantages of family planning, by including them in the traditional cultural system of the Roma community;*
- *facilitates social inclusion (obtaining social aid)* – a task not included in the RHM terms of reference.

8.2. ABBREVIATIONS

AM – Nurse

AMC – Community nurse

ANR – National Agency for the Roma

ASP – Public Health Authority

BJR – County Office for the Roma

IEC/ BCC – Information – Education – Communication / Behavior Change Communication

FD – Family doctor

RHM – Roma Health Mediator

NGO – Non-government organization

FP – Family planning

RH – Reproductive health

TR – Terms of reference

USAID – United States Agency for International Development