Country
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Background

Roma people represent the largest ethnic minority in the European Union (European Union Agency for Fundamental Rights, 2014), and Romania is one of the countries hosting the biggest Roma community. According to the 2011 Census (The National Statistics Institute, 2011), the stable Roma population in Romania is 619 000 persons, representing 3.2% of its total population. However, it is believed that this population is 3 to 4 times larger than official numbers; some estimate it at 1 850 000 people (European Commission,

2011). Compared to non-Roma, the Roma population is more likely to live in poverty, have less education (enrolment in primary education is less than 50%), lower health status and limited access to health services (Bejenariu et al., 2014). As far as health is concerned, they have higher chances of developing chronic illnesses and have a life expectancy at birth reduced on average by 10 years, compared to other populations of EU. Before the implementation of the Roma health mediation (RHM) program in Romania, relatively few Roma mothers (40%) attended pre- and post-natal care, compared to more than 70% of non-Roma mothers (Bejenariu et al., 2014).

Program description

In 1991, a first mediation program was initially conceived by the Romani Criss NGO mainly focused as a conflict mitigation project. Mediators were being trained to improve communication between Roma communities, non-Roma population and local authorities. In 1996, supported by the Catholic Centre against Famine and for Development (CCFD), the NGO reoriented the program to a health-focused mediation, principally aimed at improving social conditions for Roma and facilitating communication between Roma communities and medical providers. Additional main aims of the health mediation program were: to involve local communities in the implementation of the program; to improve access to health care and health education of Roma and to empower Roma women. Also, a more specific goal consisted in increasing pre- and post-natal care for Roma mothers.

Health mediation was included in 2001 in The Strategy of the Romanian Government for Improving the Situation of Roma; strategy which was drafted after consulting with experts and representatives of the Roma community (WHO Regional Office for Europe, 2013). Health mediation was then institutionalised, and the profession of health mediator was officially introduced by the Ministry of Labour

in the Classification of Occupations in Romania (WHO Regional Office for Europe, 2013).

In 2001, 84 women with average education level were trained in mediation by the NGO and started working for local authorities (WHO Regional Office for Europe, 2013). The programme grew steadily and was consolidated during the following years (2002-2008): the number of appointed health mediators increased significantly up to 395 appointed health mediators by 2005 and 600 by 2008 (Wamsiedel et al., 2012). In 2009, the decentralization of the health system (including the health mediation program) occurred, aiming to improve quality of health services provided by adjusting them according to specific needs of local communities. Consequently, the organisation, monitoring and coordination of the health mediation activity were transferred to local public administration. In practice, this usually meant that general practitioners started supervising the health mediators.

Despite being implemented to better fit local communities? needs, the decentralization process had several negative consequences for the program of mediation. For instance, the number of health mediators declined of about 37%, going from 600 in 2008 to 380 by the end of 2010 (Schaaf, 2011), mainly due to financial reasons. In particular, some local councils did not re-hire health mediators and some other did not replace those who migrated or found other jobs. Furthermore, the supervision of health mediators became unbalanced: some health mediators reported to multiple general practitioners, who often assigned them contradictory or hard to handle tasks; others were supervised by the local authorities, which often assigned them with non-relevant tasks.

These difficult circumstances led to the creation of a professional association of health mediators (?Zurale Romnia?) in 2010, whose main aims were to defend mediators? interests, improve their work conditions, but

also participate in the improvement of the health situation of Roma in Romania.

Characteristics and roles of a health mediator in Romania

The health mediator has the following roles in a Roma community (Wamsiedel et al., 2012; WHO Regional Office for Europe, 2013):

- Improves communication between Roma communities and medical staff
- Facilitates the access to medical services for the Roma community members; e.g. helps Roma women to attend pre-natal care by accompanying them to the practitioners
- Contributes to public health interventions by mobilizing Roma communities to take part in health campaigns (e.g. vaccination) or by identifying and informing medical staff about occurrence of transmittable diseases, intoxications, etc.
- Informs Roma community on rights and responsibilities of the State towards citizens
- Provides information on the functioning mode of the health and health insurance systems; as well as basic health information (e.g. use of contraceptive means, non-pharmaceutical steps, such as handwashing, to avoid spread of disease)
- Help Roma people without identification papers (e.g. birth certificate, Identity card, etc..) in the process of obtaining them

Lessons learned and challenges

The fact that health mediators were **women** played an important role in the success of the program, since Roma social conventions proscribe discussing several sensitive issues (e.g. prenatal care, health issues) in presence

of men. Another factor of success of the program is that health mediators are part of the Roma community. Thus, they were easily accepted, and considered more trustworthy by the community. This increased the efficiency and impact of the actions of the mediators (Bejenariu et al., 2014).

Bejenariu and co-workers (2014) evaluated the effects of the health mediation program on prenatal care and child health in Roma communities, using data from the Vital Statistics Natality and Mortality files, and from the Roma health mediators? registry. They concluded that the program significantly increased attendance of Roma women to prenatal care appointments. However, no improvements were observed in low birth weight or premature delivery, but the number of stillbirths and infant deaths decreased slightly following the implementation of the program.

Health mediators raised awareness on subjects such as family planning, healthy lifestyle, vaccination and hygiene and might have contributed to a change in Roma?s health-related behaviour (WHO Regional Office for Europe, 2013). As a matter of fact, many of health mediators? duties concern the area of infectious diseases, such as reporting the number of identified cases of tuberculosis, promoting health vaccination campaigns and inciting Roma populations to participate, as well as assisting the medical personnel during vaccination campaigns. However, there is very few data concerning translation of these behaviours into tangible actions: going more often to the doctor, vaccinate their children, etc.

Concerning vaccination rates, data is scarce; it is not known how much the RHM program improved vaccination rates among Roma communities (Schaaf, 2011). This may be due to the fact that unvaccinated Roma people are also often undocumented. Multiple evaluations of the program considered it a success and a model for future implementation of health mediation programs, as a close collaboration

between NGOs and government (WHO Regional Office for Europe, 2013), with high geographical and demographical coverage. It was estimated that 660 000 Roma have been served by a HM at some point; this represents between one third and one fourth of the Roma population in Romania. However, they also pointed out some major faults and avenues for improvement, and identified several challenges encountered during the implementation process, such as insufficient training, poor work conditions (low salaries, fixed-term contracts, job insecurity, etc.) and the decentralisation, which impacted the activity of health mediation.

The following recommendations not only indicate ways to improve the current health mediation program, but should also be considered when designing and implementing a new health mediation program (Schaaf, 2011; WHO Regional Office for Europe, 2013):

- **Involve the target group in all phases of the project**
- Better organize the supervision of health mediators, by defining more clearly who takes the responsibility of supervision and to whom health mediators have to report
- Provide adequate funding and consequently ensure job security of health mediators
- Provide high quality training to health mediators, but also sensitise the medical body involved to existing cultural differences

Status of the project

The project of Health Mediators in Romania is still ongoing. It has been implemented in other countries with important Roma communities across Europe:

- **France**: there is a national health mediation program that started to be implemented during the period (2010-2012). National coordination of the

project is ensured by the Association pour l?Accueil des Voyageurs (ASAV) (*see best practice document on Health Mediators in France*).

- **Serbia:** The health mediation programme was initiated in 2008 by the Serbian Ministry of Health in cooperation with OSCE and the European Agency for Reconstruction.
- **Bulgaria:** the Health mediator model was launched in 2001 by the team of ?Ethnic Minorities Health Problems Foundation? (*see best practice document on Health Mediators in Bulgaria*)
- **Macedonia:** the health mediation program was launched by the Macedonian NGO HERA (Health Education and Research Association) in 2009-2010, with support from the Open Society Foundations.
- **Slovakia**: The Roma Health mediation program started in 2005, as part of a larger program that was funded by PHARE.
- **Ukraine:** The Roma Health mediation program started in 2010, coordinated by the Ukrainian NGO Chiricli in collaboration with the Ministry of Labour and Social Policy and other non-governmental bodies.

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