



A mixed-methods evaluation of Roma health mediation

Bulgaria case study

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ABSTRACT

Efforts to bridge the health gap of Roma people compared to the general population in the EU have been renewed through the adoption of National Strategies. The Roma Health Mediator programme takes an active part in the Bulgarian Strategy by providing a range of social and health-related services. This essay evaluates the relevance, effectiveness and sustainability of such a programme. The analysis shows various interconnected strengths of the Bulgarian mediator model. It also identifies issues of fragility related to the decentralised approach focussed on municipalities, on the one hand, and to the lack of a supportive macro-level welfare system, on the other.

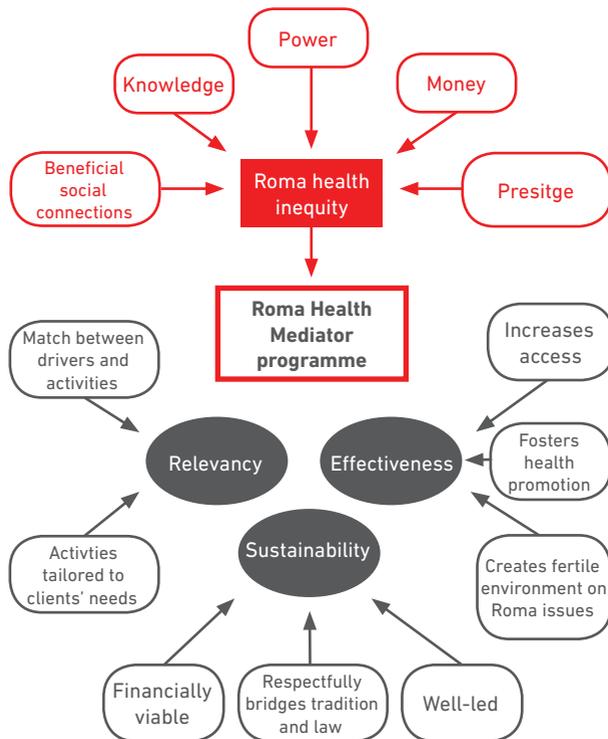
INTRODUCTION

An overview of Roma health inequity in the EU offers a grim picture, as Roma lag behind in terms of mortality, morbidity, immunisation rates, health insurance coverage, and healthy lifestyles (European Commission, 2014). Efforts to tackle Roma disadvantage have been renewed through National Roma Integration Strategies, wherein the Bulgarian health mediator programme takes an active part. In this essay, I attempt to answer the evaluative questions of whether the Roma health mediator programme in Bulgaria is a relevant, sustainable and effective policy to tackle the underlying drivers of Roma disadvantage, and what the mechanisms that favour and hinder intervention are (Pawson and Tilley, 1997). In terms of relevance, I seek to ascertain whether there is a close match between the drivers of disadvantage and the activities performed, and the extent to which mediators can tailor such activities to the specific needs of their clients. As for effectiveness, I seek to provide evidence that health promotion is fostered, access to healthcare is increased, and a more fertile environment for addressing Roma needs is created. Regarding sustainability, the focus is on intercultural, organisational and financial elements.

The study is divided into three parts. The first introduces the problem of Roma health inequity and its underlying drivers, which health mediators seek to address in their daily encounters with people (clients, doctors, municipal coordinators and other social workers) in the field. It also briefly considers the EU and national policy context wherein the programme takes place. The second part clarifies the reasons for adopting a mixed-methods research approach, together with a description of the data collection (survey, interviews) and analysis techniques (descriptive and inferential statistics, thematic network analysis), followed by the manner and stages at which methods were combined. The third section analyses the activities the mediators perform, with

an emphasis on what hinders and facilitates action, and what the main qualitative outcomes and quantitative outputs are. It also investigates three strongly interlocked aspects that may influence the programme, in particular the extent to which it is financially viable, well led and responsive to clients' needs: (i) the internal and external coordination of the activities; (ii) the motivation and discretion of the mediators, which are seen as "street-level knights" to combine Lipski's (1980) and LeGrand's (2003) inputs; and (iii) their training and selection. Lastly, the conclusion summarises the analysis by providing recommendations.

FIGURE 1 CONCEPTUAL MAP



Source: Author.

BACKGROUND

In Bulgaria, data indicate a strong health disadvantage for Roma populations (Gitano 2009, UNDP 2012). According to Link and Phelan's (1995) "fundamental cause" approach; when a population develops the means to avoid disease and death, individuals' ability to benefit from that wherewithal is "shaped by resources of knowledge, money, power, prestige and beneficial social connections". Barriers to healthcare access are an important cause of health inequities. Such barriers could be both formal and informal, from the supply and the demand side.

Firstly, regarding *de jure*/formal barriers, Bambra (2007) highlights how research on health inequity has increasingly integrated a welfare state perspective. Since the fall of the communist regime, Bulgaria has reformed its healthcare services vis-à-vis financing, organisation and delivery. Waters *et al.* (2008) show how most Central and Eastern European (CEE) countries moved away from centralised health systems and instead adopted a social health insurance model. In Bulgaria, insurance coverage was introduced in 1999, excluding the most vulnerable. Besides, in 2015, the number of months of arrears to be paid to restore one's entitlement to insurance increased. Secondly, regarding informal barriers, the literature highlights out-of-pocket payments, lack of services or transportation to healthcare facilities, low health literacy, mistrust, discrimination, lack of accommodation of cultural differences, and Roma traditional beliefs (Atanasova *et al.* 2012, Colombini *et al.* 2012, Hajioff and McKee 2000, Zoon 2001).

Such challenges have not gone unnoticed. In 2005, the Declaration of the Decade of Roma Inclusion 2005–2015 was signed. In 2011, the European Commission's Communication on a EU Framework for National Roma Integration Strategies (NRIS) up to 2020 asked member states to devise integration strategies, to be implemented through an Action Plan. The Action Plan for the implementation of the National Roma Integration Strategy of the

Republic of Bulgaria (2012-2020) and the Decade of Roma inclusion 2005-2015 include health mediators in many activities. Mediators act as a bridge between Roma and institutions, improving access to healthcare by reaching across prejudices and overcoming lack of information. The health mediation programme was originally piloted in Kjustendil in 2001 by the Ethnic Minorities Health Problems Foundation. In 2005, with the start of the Decade, the Bulgarian government adopted the Health Strategy for Disadvantaged Persons Belonging to Ethnic Minorities, wherein the mediators played a significant role. In 2007, the mediator profession was included in the National Classification of Occupations, and supported financially by the state. In the same year, the National Network of Health Mediators (NNHM), including mediators and experts, was founded. In 2016 funds have been allocated for a total of 196 health mediators.

METHODOLOGY

Mixed-methods

Quantitative and qualitative approaches are traditionally understood as following different logics of enquiry due to differences in their epistemology, ontology and role of theory. This rift is at the basis of the incompatibility thesis, according to which it would be inappropriate to mix methods due to such incommensurability. However, the rejection of an 'either-or stance' has long been part of the mixed-methods literature (Campbell and Fiske 1959, Howe 1988), thus supporting methodological eclecticism. Mixed-methods are used for three main reasons: firstly, to confirm results through triangulation, given that "the weaknesses in each single method will be compensated by the counter-balancing strengths of another" (Jick 1979: 613). Secondly, to offer a different part of the whole, so as to add meaning and

understanding to the underlying mechanisms at hand. Thirdly, to clarify surprising findings; what Green, Caracelli and Graham (1989) call “initiation.” In this study, the methods were mixed throughout, rather than being compartmentalised: firstly, the literature review, documentary analysis and a cognitive interview helped to devise the survey; secondly, the results of the survey helped to sample the interviewees; and, thirdly, the quantitative findings are integrated with the qualitative ones.

Data collection

The methods used are a self-completion survey administered through “qualtrics” by the mediators and 8 face-to-face semi-structured interviews with the mediators, experts of the NNHM, a representative of the Bulgarian Family Planning Association (BFPA), and with the National Council for Cooperation on Ethnic and Integration Issues (NCCEII). The main benefit of the self-completion survey is that it made available a substantial portion of the mediators with a high degree of data standardisation. Semi-structured interviews allowed getting a “worm’s eye view,” as opposed to the macro-level “bird’s eye view” made possible by survey data (Hakim 2000). In surveys, respondents have a limited ability to fully express what they mean when selecting among variables, and the fact that it is difficult to build a rapport may negatively influence the truthfulness of answers. By contrast, through probing and targeted questioning, while interviewing, the researcher obtains clarification and expansion of meanings (Gaskell, 2000). Whilst interviewing has been criticised too (Dean and Whyte 1958, Becker and Geer 1957, Deutscher 1973), answers to different questions and from different stakeholders were triangulated and individuals were interviewed in sufficient detail for the results to be taken as truthfully disclosed, correct and complete, and thus internally valid.

Regarding interview sampling, mediators from different regions, both women and men, recently employed and with previous experience, working in rural and urban settings, or who had provided a 'deviant' survey answer were sampled. Hence, contrary to a homogenous sample whose purpose is "to describe some particular subgroup in depth" (Patton 1990, 235), the method was a maximum variation one, which tended to identify core patterns and reasons for variation. Lastly, two interviews were conducted with experts of the National Network who introduced me to NCCEII and BFPA representatives (snowball sampling).

Data analysis

The survey included two parts: the first used a 5-point Likert scale to measure the extent of agreement regarding 4 items: discretion-goal, discretion-client, mediator willingness, and job meaningfulness. The second used ranked responses vis-à-vis priority activities: improving health education, preparing documents, accompanying individuals to healthcare service centres, raising doctors' intercultural awareness, patient advocacy towards institutions, and improving communication between Roma and medical professionals. The Likert scale items were analysed with measures of central tendency of the frequencies, highlighting the modal category. Secondly, regarding ranked responses of priority activities, descriptive statistics and a one sample z-test for evaluating proportions were carried out: improving health education was a statistically significant first choice, as discussed in the next section.

Interviews were interpreted through thematic network analysis. This process entailed the classification of coding to identify global, organising and basic themes (Attride-Stirling 2001). The coding process was primarily inductive but could not be separated from a certain degree of deductive *a priori* templates. Relevant quotes are presented throughout this paper so as not to lose sight

of the rich experiences. Presentational sampling (Flick 2002, 61) was a particular challenge, as it necessitated the sacrifice of vivid descriptions for the sake of brevity.

THE ROMA HEALTH MEDIATION PROGRAMME

Activities

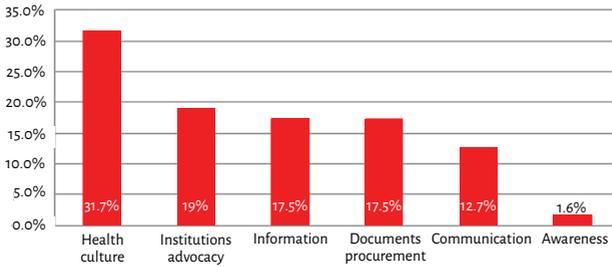
Roma health mediators are health workers hired by municipalities to advise and support Roma communities. They provide a vast range of both social and health-related services, which can be grouped into three main kinds of activities: health education, assistance in accessing healthcare and advocacy. Personal contact with a range of stakeholders is central and their work is mainly in the field – only a small part is in the office. Mediators strive to act as a bridge between the vulnerable, poorly integrated, and lower-educated Roma communities, on the one hand, and the institutions, on the other. According to the National Network of Health Mediators' 2015 monitoring report's raw data, the total number of service instances provided was 130,657. The largest share of operations concerned assistance in carrying out prophylactic examinations, immunisations, and campaigns in the field of reproductive health and prevention of various diseases (65,931 or 50.46 per cent). The second consisted of counselling and preparation of documents, accounting for 37,500 of the outputs (28.70 per cent). The third, accompaniment to health and social services, accounted for 15,066 of the activities or 11.53 per cent. Lastly, 12,360 services (9.45 per cent) were aimed particularly at the poor, pregnant women, older people living alone, etc.

At a first and rather superficial glance, the data would seem to suggest that activities in the field of accessing healthcare, rather than health education, are prioritised. However, the way the output data is collected does not make it easy to distinguish between

the two types. For instance, the counselling and documents category conflates two rather different activities. Besides, it would be incorrect to make a sharp, clear-cut division between the two: firstly, vaccinations or assistance with sexual and reproductive health programmes entail as much technical assistance as the delivery of information regarding their benefits. Secondly, by accompanying individuals to healthcare service centres, mediators not only work as interpreters and cultural brokers but also raise General Practitioners' (GP) awareness of the needs and rights of Roma, as a result creating a more fertile environment. Thirdly, by navigating Roma through the social and health services, they make them acquainted with the different systems in the process. The Network's monitoring data, therefore, does not allow to measure whether the programme focuses on healthcare access or health education, nor can the complex nature of such activities be fully grasped by relying on these quantitative outputs.

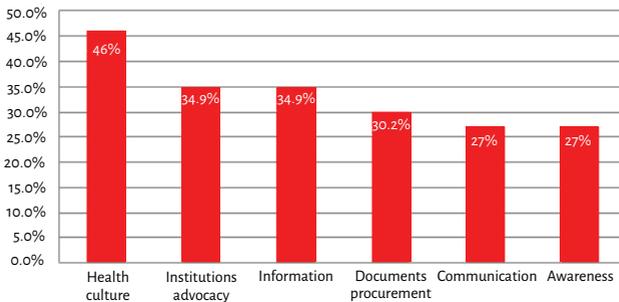
The reason why this is highlighted is because, while the group of diverse activities pertaining to health education can be seen as an investment in health, the cluster of services devoted to improving and increasing access to healthcare can be seen as favouring healthcare consumption. To an extent, it is reasonable to consider the latter activities as a somewhat inferior kind, because they are not centred on engendering long-term sustainable change, but rather on tackling short-term health needs. Yet, as discussed above, there is more to them than meets the eye. Since, based on the available monitoring data, it was hard to measure the extent to which health investment or consumption were prioritised, mediators were asked in the survey to rank six activities: improving health culture, advocacy with institutions, providing information on the health and social services, documents procurement, improving communication with GPs, and raising the awareness of medical professionals vis-à-vis Roma needs. Improving health culture stands out as the highest ranked option, as can be seen from Figures 2 and 3:

FIGURE 2 WORKING ACTIVITIES IN ORDER OF IMPORTANCE - 1ST CHOICE %



Source: Author.

FIGURE 3 WORKING ACTIVITIES IN ORDER OF IMPORTANCE - 1ST/2ND CHOICE %



Source: Author.

Besides, a z-test for evaluating proportions of the same population assuming a hypothesised value of 16.6 per cent, which is equivalent to indifference among the six options, found a clearly statistically significant deviation from the indifference percentage for improving health culture as option one and as combined option one and two, significant at the 0.1 per cent and 5 per cent levels respectively.

Therefore, the outputs of the monitoring activities only tell a partial story, as mediators put a lot of emphasis on empowering

the Roma – on health investment, rather than merely its consumption. Mediators not only bridge the gap between Roma and institutions, but also attempt to reduce the gap to be bridged, thus aiming at health promotion, a “process of enabling people to increase control over, and to improve, their health” (Ottawa Charter, WHO 1986). As a mediator puts it: “besides helping people, we have to inform them, so that they can help themselves eventually.”

In this regard, it ought to be highlighted that, instead of accompanying people to healthcare service centres, mediators may refer the clients to the appropriate place, with the intention of having them learn:

“If people need me less I think this would be a great achievement [...] I tell them to go alone, do this and that, and see that nothing scary will happen, not because I don’t want to go but for them to be independent, to learn.”

According to the mediators’ self-assessment of the outcomes, lack of knowledge and of beneficial social connections (with GPs, role models, mediators) have been overcome. The outlook is not exclusively optimistic, however, as mediators emphasise that change is slow and difficult to sustain with regards to “hardly negotiable” topics because of the clash with family and community values. Evidently, the social structure plays an influential role in shaping life’s goals and health outcomes: early marriages, from 14–16 years old, are socially encouraged, and the key goal becomes having children, “so that people don’t start gossiping [that] they can’t.” However, mediators underline positive outcomes with those most eager to access new sources of information as compared to the traditional sources they would otherwise be confined to – thus, offering a chance to the autonomous agent to make a choice. The tension between individual agency and community structure and values is best described by a mediator:

“I understand a person is very rich when [they] know both cultures. I am a Bulgarian of Roma origin. So one is rich when [one] can choose and decide for her own children. How to raise them? Should they follow the traditional way or go beyond that in the wider society, [which is] more difficult and challenging but ultimately better?”

As for what facilitates action, firstly, it should be stressed that mediators are both men and women. This gives a fuller range of options as for who is to address specific target groups or individuals – for instance, male mediators may find it easier to talk to husbands, who ultimately take the final decisions regarding family planning and reproductive health. However, this arrangement does not hold in all contexts, as for instance only one mediator may be employed in a municipality or, if there are two or more, they may work in different neighbourhoods.

Secondly, if education and job mediators are also employed in the municipality, it is possible to create synergies across the critical areas of exclusion. This is because, while mediators can be resourceful and work on many dimensions of the drivers of Roma health inequity, they cannot tackle each of them, such as material causes linked to entrenched poverty and lack of insurance:

“When a woman needs to change the spiral, I use my personal connections so that I can get an appointment with the doctor, but the woman still has to pay 15 leva. There needs to be an examination before inserting [the pap smear], and the examination is 20 leva. But they do not have the 20 leva for it, so they do not put the spiral sometimes.”

As for lack of insurance, mediators emphasise that emergency treatment (in accordance with Decree 17 of 31st December 2007) and one visit to pregnant women (in accordance with Ordinance 26 of 14th June 2007) are accessed primarily through their sup-

port. Roma clients would hardly know about such entitlements otherwise.

The third facilitating mechanism is linked to the constant work with certain GPs. This has improved the relationship between physicians and the mediators, as well as between GPs and Roma. Mediators were keen to emphasise that the most troubling relationships are with medical specialists, rather than with GPs. The improved awareness and intercultural skills of GPs is a result of sustained cooperation. Similarly, social services appear to have become more responsive, thus decreasing meso-level barriers to accessing welfare. An opportunity to further decrease these barriers stems from the fact that health mediators in certain municipalities have started to work in local hospitals, too.

Coordination

The financial and activity-related coordination of the Roma health mediator programme takes place at different levels. The programme has sustainable features in that the mediators are paid by the Ministry of Health through the Ministry of Finance's delegated budget. However, the budget is approved on a yearly basis, rather than on a multi-annual one. Despite there being room for improvements in this regard, so as to plan in the medium to long term, the current financing structure marks an improvement from the period of the early 2000s, when ad-hoc projects were the channel through which to train and hire mediators. Nonetheless, the National Network of Health Mediators, together with its partner organisations, constantly look for further sources of financing from external donors, which could be international, foreign, as well as Bulgarian, and public as well as private.

The mediators, through the abovementioned delegated budget, are employed by the municipalities. Each year the National Network of Health Mediators prepares a list with the municipalities that should receive financing by the state, based on

their needs-analysis and monitoring activities. This list is sent to the Ministry of Finance and the Ministry of Health. A great deal of coordination is possible thanks to the work of the National Council for Cooperation on Ethnic and Integration Issues (NC-CEII). The NCCEII is the consultative and coordinative body of the Council of Ministers. It helps to implement and monitor the National Roma Integration Strategy and its Action Plan. Furthermore, there exist 28 regional strategies (one per region) and more than 300 municipal action plans (out of a total of 365 municipalities). “The regional strategies and municipal action plans follow the structure of the National Strategy, provide information on local Roma communities, and specify the national aims depending on the different contexts” (IOM 2014, 19).

The National Network of Health Mediators is accountable to the NCCEII, to which it sends a report every year. The mediators send a report every six months to the National Network; it is on the basis of these reports that the final yearly report to be sent to the NCCEII is compiled. Coordination may also take place rather informally:

“Members of the National Council ought to submit a short yearly report of their activities for monitoring purposes. But when we need some special information we can get in touch more directly.” – NC-CEII

In addition, mediators send a monthly report to the municipality that employs them. The extent to which the various municipalities are eager to support the work of mediators, or are interested in and knowledgeable about their activities and issues at stake, changes widely across the country and over time. There is also a degree of variability in the extent to which regions operate proactively:

“It’s a bit of everything, there are regions that are very active and where mediators are included in different regional initiatives, funded by different donors, there are regions in which things are more quiet” - BFPA

Also, regarding health planning at the local level, the views of the mediators pertaining to their inclusion vary:

“When they write the strategy they would ask me to sit together to support, inviting me in working groups so that my opinion is heard and taken into account.”

“So far they have kept us on the side. In three or four years, they have only invited me to one meeting.”

Taking a bird’s eye view of the process of coordination and strategic planning of activities, it seems that the way priorities are set takes into account the interplay of different actors and the context wherein the planning process takes place (Buse 2005), thus shying away from a rigid top-down, rational model of strategic planning of activities (Simon 1945, Marinetto 1998). The internal coordination of the Network favours such a worthwhile approach. The Network has an online forum in place, which allows the mediators to exchange information quickly and horizontally, rather than only vertically (mediator-Network) every 6 months. Besides, Network coordinators perform field visits to different geographical areas throughout the year. Therefore, the Network is in a position to inform policy at the national level by having close links with the local mediators – and awareness of the needs of the Roma – and by having both formal and informal linkages with the National Council.

Moreover, mediators are richly resourceful in the information they may provide regarding the structural, cultural, and health needs of the Roma. The job description requires the mediators

to be from the community they work in. Therefore, even if the mediator has just been employed, she or he possesses a personal experience of the context. Further to this, the fact that the job description requires them to have at least a high school education allows them to have a critical understanding of the problems, enhanced by the thorough training they receive. In the municipalities where mediators have long been active, more experienced mediators help new recruits to better understand the context, as they possess a longitudinal experiential background related to the community. This bottom-up process is best expressed in the words of a mediator:

“We know the territory and the people, we know who is sick, what needs there are in the community, and that’s how we come to know: when we go there and see and talk to people.”

Externally, the National Network of Health Mediators has created a network of partnerships with other NGOs. One of the NGOs that most contributed to the activities of the Network is the BFPA, the national affiliate of the International Planned Parenthood Federation (IPPF), which has been active in Bulgaria for 25 years. Such a policy community resonates well with Lewis’s (2005) idea of it, inasmuch as it has developed through formal and informal interaction of its participants across time.

Street-level knights

Social and public policies are best understood in the daily encounters of street-level workers (Lipsky 1980) rather than as a top-down implementation of laws by high ranking administrators, albeit with varying degrees of flexibility or participatory components. This is because front-line staff interact directly with citizens, have discretion in their job, and thus are active makers of policy. Hence, the way the policy under investigation is ultimate-

ly shaped on the field depends heavily on whether the mediators are motivated (have “willingness”) in their job, and what affects their motivation. It has been argued that street-level bureaucrats want to make a difference to their clients’ lives (Maynard-Moody and Musheno, 2000), thus portraying their job as “meaningful”. This in turn increases their motivation to implement the policy (Tummers and Bekkers 2014).

With regard to discretion, the survey separated the concept between treatment of the client (discretion-client) and discretion towards the goal to be achieved (discretion-goal). The mediators appear to perceive a very strong degree of discretion. In both instances the modal category was ‘strongly agree’ (60.32 per cent for discretion-client, and 63.49 per cent for discretion-goal), thus supporting the literature’s insight that front-line staff generally enjoy a high degree of discretion. Conversely, a mediator who felt she could not tailor her job to client needs (discretion-client) explained in the subsequent in-depth interview that: (i) the high number of clients did not allow for adapting the intervention to the needs of each client; (ii) it would have been preferable to have the office in the Roma quarter so as to be closer to the community and thus more effective in performing the duties; and (iii) there had been instances where the needs of certain clients (drug addicts, a mother whose child had died in an institution), who had turned particularly aggressive, could not be addressed. This powerful explanation bears important policy implications. Firstly, it highlights that the programme is understaffed in some contexts. Secondly, it underlines the tension between creating an ad-hoc Roma structure and favouring mainstream healthcare access. Thirdly, it supports the understanding that mediators face dire challenges in the job, including violence and threat of violence, and thus require strong commitment to overcome them.

Indeed, for “meaningfulness” and “willingness” , the modal category is ‘strongly agree’ (58.7 per cent and 74.60 per cent), with cumulative percentages of ‘strongly agree’ and ‘agree’ of 98.4

per cent and 93.7 per cent, respectively. According to the mediators, their profession is more of a vocation than a job. The fact that the mediators are Roma themselves goes a long way in explaining such dedication:

“I have accepted it as a *mission*. I didn’t start for the money, I didn’t need any, my husband has his business, the salary is very bad.”

“One of the biggest challenges for the Roma community is health. So, I wanted to be of help to *my* people [...] I thought I could be a *saviour*.”

Mediators can be primarily seen as public-spirited altruists – as knights rather than knaves, to use LeGrand’s (2003) distinction vis-à-vis healthcare service employees. According to LeGrand, “knaves can be defined as self-interested individuals who are motivated to help others only if by so doing they will serve their private interests; whereas knights are individuals who are motivated to help others for no private reward, and indeed who may undertake such activities to the detriment of their own private interests” (LeGrand 2003, 27). Indeed, the programme tends to select knights and dissuades knaves (low pay, heavy workload, threats of violence, non-monetary rewards, etc).

However, knights and knaves coexist within any organisation (ib. 2003). For some mediators the job is merely a temporary activity while studying or upon entering the job market. In this case, the same aspects that select for knights prove counterproductive. This is because the challenges faced negatively impact staff turnover, thus squandering the resources used for recruitment and training, and those forged with clients and other stakeholders, jeopardising the sustainability of the programme. What is even more problematic is that such weakness is not limited to temporary job-seekers alone. As the interviews clarified, turnover due to the programme being understaffed and the workload

too burdensome may as well affect knightly mediators. Digging deeper, as highlighted by the representative of the BFPA, “there are also places with lower numbers of Roma per mediator, but worse problems” – thus, the quantitative approach to caseload only tells a partial story, but cannot be overlooked altogether in shedding light on turnover or effectiveness.

Selection and training

The criteria for the selection of health mediators include being from the community they work in, a minimum of high school education, and the ability to speak the language of the local community. Every year, the Network provides the relevant Ministries with the number of mediators needed. A budget is allocated by the Ministry of Finance and received by the municipalities. A municipal commission is set up to examine the candidates for the job openings, which include representatives of the municipality, the regional health inspectorate and mediators. However, certain municipalities do not want to include the mediators in such commissions. According to various interviewees, it is very difficult to work with municipalities because local political motives may prevail. By contrast, it is easier to work at the national level, as it was at the beginning of the programme, before the municipalities were put in charge. Therefore, while there is a structured coordination system, there seem to be threats of fragility.

Similarly, critical issues pertaining to the firing of mediators persist. In one municipality, the mayor wanted to remove a very proactive and capable mediator with nine years of experience and substitute them with an individual who had supported him in the electoral campaign, according to a representative of the National Network. Conversely, there are also instances where less skilful mediators, according to the monitoring activities of the Network, are kept in place because their inability to bring about change matches the (lack of) will or enthusiasm of the political elites. The

National Network has to intervene on a case by case basis in these circumstances, so as to defend the rights of the mediators and the effectiveness of the overall programme. In such cases, the Health Commission of Parliament, the National Council, the Ministry of Finance, and the Ministry of Health are informed in order for them to take action.

It would be advisable to put in place a strengthened hybrid system, wherein mediators who perform above a given threshold, according to the monitoring activities of the Network, cannot be fired on a legal basis. Nonetheless, such proposals fall short of countering another threat as, in some cases, the municipalities have insisted that mediators sign a resignation letter while being (falsely) promised another job. The Network has now thoroughly counteracted such practices by informing the mediators not to sign any documents without first informing the Network. An interviewee referred to the Belgian experience as a good practice for comprehensively countering such threats. In Belgium, the NGO Foyer is independent from the local authorities, and the whole process of hiring, retaining or firing, and assigning activities to the mediators, is more transparent, not linked to political goals, and therefore more effective. Despite this, issues pertaining to path dependency may arise – it could be very costly at this point to change the overall structure altogether. Besides, the fact that the municipalities are involved may also present positive aspects, as this expresses (or does not) the local political will, on the one hand, and because it may favour the education of the political elites given such institutionalization, on the other. Taking all this into consideration, a hybrid, somewhat consociational structure, between the Network and the municipalities, could represent a second-best option, and an improvement compared to the current threats and the exhausting need to act on a case by case basis. A more thorough comparison of the Belgian and Bulgarian experiences, as a “most different system” design (Przeworski&Teune 1970), could be worthwhile.

The training of the mediators seems apt to increase their professionalism and capability. Training consists of classes in a medical university, it is 2-weeks long, and includes several hours of medical training with professionals. This is probably the most striking difference, and strength, of the training as it is now compared to how it used to be. While there has always been training for the mediators, in recent years it has included a more thorough medical education. The way the training is now organised is multidimensional: health-related information is coupled with a more practical component, such as information about the health system, health insurance legislation, social security, communication skills, how to report, how to organise time and activities, etc. Indeed, the role of mediators presupposes and requires such a synergetic mix. The training is prepared by the Network, as a mediator puts it:

“The Network is a source of information, we could not manage without them, we could not work without them [...] We don't lack training, our colleagues prepare training for us very diligently.”

Crucially, there are also ample opportunities for continuous training updates while being employed, both through the Network or the BFPA, which includes the mediators in their trainings focussed on prevention of cervical cancer, or hepatitis B and C, among others, or the Council of Europe's ROMED training, in which mediators participate on a rotating basis. By contrast, a weakness of the training is that it only addresses the mediators. With the initial PHARE programme, wherein the programme was piloted, service providers were also included.

CONCLUSION

Roma health mediators possess a warm and communicative working culture, which they put to use to mediate conflict, misunderstanding and distrust; to protect the rights of their clients; and to enhance their clients' knowledge of, and beneficial connections with, the health system and social services. In so doing, they provide an answer to the micro- (community, individual) and meso-level (institutional) drivers of the “unequal distribution of opportunities to lead a flourishing life” (WHO 2008) – from both the supply and demand sides, and in a bottom-up yet institutionalised fashion. The programme is not a panacea, however, as certain challenges require time to be effectively countered or, like poverty, fall outside its scope. Nor can mediators do more than cultivating health promotion or help bridge the gulf between *de jure* entitlements and *de facto* access. Therefore, the macro-level context ought to be consistent with the objective of Roma inclusion. By contrast, insurance policy, with the increased amount of arrears required to be paid to restore one's health insurance, clashes with the goals set in the National Roma Integration Strategy. It is important to stress the risk of merely opening a “can of health mediators” in order to solve Roma problems, although the mediators do indeed perform an extremely important job – a number of jobs, in fact.

There can be good and bad mediators. Mediators' motivation and perceived job meaningfulness for their community of belonging is crucial in order to overcome the material and emotional hardships of the profession. Hence, it is important that a fair, meritocratic, and apolitical system to hire and retain mediators be put in place: (i) by redistributing powers to the Network to the detriment of the municipality in a more consociational structure; (ii) by hiring mediators and taking into account the number of clients and the pervasiveness of the contextual problems; (iii) by paying higher salaries, to retain well qualified and experienced

mediators. Furthermore, working on a longer strategic horizon is required for sustainability, and multi-annual financing should replace the current, year-by-year framework.

By intervening in their own community, mediators reduce the risk of a “white man’s burden” approach, which forcefully simplifies contextual complexities and splits into a Manichean light and darkness. By contrast, mediators are a bridge between tradition and law. Their approach is a dedicated and delicate one to spanning the “us versus them” gap: understanding where it is possible to act directly, and what the “hardly negotiable” topics to be dealt with more diplomatically are. Their voices are particularly valuable when heard and heeded throughout the health planning stages. Mediators’ inputs are rich and insightful because of their own background and training. Planning more broadly, however, should seek to include a wider range of stakeholders, so as to create a fertile environment that counters anti-gypsyism. More mediators could be employed in hospitals, so as to improve the difficult relationship with medical specialists, similarly to what has been done with GPs who constantly work with mediators and Roma patients.

In conclusion, the programme is highly relevant because it allows practitioners to tailor interventions to the needs of their clients, and to tackle four out of the five main drivers of health inequity, namely: lack of knowledge (health promotion, information), beneficial social connections (with service providers, Roma role models), power (advocacy, policy community) and prestige (sustained cooperation, decoupling of stereotypes). It cannot tackle households’ lack of capital. It is highly sustainable culturally because it strives to bridge tradition and law without creating a parallel system and without being biased by a “white man’s burden” approach; it is sustainable financially, but a multi-annual budget would be an improvement; and it is only somewhat sustainable in leadership, because of the threat of municipalities’ un-cooperativeness. The programme is highly effective in increasing

healthcare access, and effective in engendering long-term health promotion. It is somewhat effective in creating a fertile environment, as the scope of training needs to be broadened.

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