



Health Mediation models in the EU: Examples of good practices

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This document has been elaborated within the framework the International Organization for Migration (IOM) project “Fostering health provision for migrants, the Roma and other vulnerable groups” (Equi-Health), specifically under the sub-action on Roma Health. The Equi-Health project is co-financed under the 2012 work plan, within the second programme of Community action in the field of health (2008-2013), by a direct grant awarded to IOM by the European Commission’s DG for Health and Food Safety (DG SANTE), through the Consumers, Health, Agriculture, and Food Executive Agency (CHAFEA).

The report ‘Health Mediation models in the EU: Example of good practices’ compiles health mediation models from participating project partner countries to the Regional Intervention on “Health Mediation and the Roma”, launched within this framework and in line with the priorities identified at the Regional Consultative Meeting & Expert Working Group “Health in the EU Framework for National Roma Integration Strategies: Implementation, Challenges and the Way Forward” (Sofia, May 2013) and the Expert Working Group “Health Mediation and the Roma” (Huelva, September 2013, as part of the Conference on Intercultural Mediation in Health Care) to consist of study visits to EU Member States (MS) implementing Roma health mediation programmes with the objective to learn from individual programme experiences.

This report has been produced by National Network of Health mediators (NNHM) in Bulgaria and with the collaboration of project partner countries: Hans Verrept, FPS Health, Safety of the Food Chain and Environment (Belgium); prof. Ivaylo Tournev, Ognian Kamenov, Diliiana Dilkova and Vanya Ivanova, National Network of Health Mediators (Bulgaria); Michal Kubo, Healthy Communities, n.p.o. and Magdaléna Rothová, Association for Culture, Education and Communication (Slovakia); Marta Escobar-Ballesta and Manuel García-Ramírez, CESPYPD-Universidad de Sevilla, Javier Arza, Universidad Pública de Navarra
Tona Lizana-Alcazo, Catalan Agency of Public Health - Health Ministry of the Catalan Government, José Antonio Jiménez y Marlen Menéndez, Asociación UNGA (Spain); and Lucile Gacon, National Health Mediation Program (France).

IOM MHD RO Brussels staff, Mariya Samuilova, Isabelle Beauclercq and Jordi Noguera Mons supported with the edition and revision of this report. We thank DJ Krastev for his copy-editing, proofreading, and general editing assistance.

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BELGIUM - Intercultural Mediator

Available estimates from the Council of Europe suggest there are about **30,000 Roma living in Belgium**, which represents 0.29% of the total population. According to the National Roma Integration Strategy (NIRS), there are four main groups of 'Roma' in Belgium, which can be subdivided on the basis of their migration history. The first three groups are composed mainly of Belgian citizens:

There are four main groups of 'Roma' in Belgium: Manouches, Roma, Voyageurs, and Roma migrants.

- **'Manouches'**: the Belgian Sinti (similar to those in France, Switzerland, and certain areas of Germany), self-identified as Manouches. There are around 1 500 Manouches living in Belgium.
- **Roma**: descendants of Roma who arrived in Belgium following the abolition of slavery in Moldavia and Wallachia in 1856. There are around 750 Roma living in Belgium.
- **'Voyageurs'** (Travellers): indigenous Belgians, descendants of former itinerant craftsmen. Ethnically they are not linked to the Roma, but they share certain cultural characteristics associated with their nomadic lifestyle (housing, mobility, trades). They currently live in caravans or houses. Their first language is Dutch (in Flanders) or French (in Wallonia), but they still use a lot of words that have been borrowed from their own language, Bargoens. It is estimated that there are around 7 000 Voyageurs living in Belgium.
- **Roma migrants**: The first Eastern European Roma came to Belgium after World War Two (among others, Yugoslavian Roma looking for work). However the major influx of migrants was triggered by the fall of the Iron Curtain. The NRIS refers to the estimates of the Council of Europe ("around 30,000 Roma living in Belgium"), but it is unclear whether this applies to migrant Roma or the whole Roma population in Belgium. According to the glossary of the Council of Europe, the term Roma "covers a wide diversity of the groups concerned," thus the estimates do not seem to apply exclusively to Roma migrants.

The majority of these Roma have kept their original nationality and the residence status of many of these Roma is precarious. However, an increasing number of Roma have been granted Belgian residence permits. Most of them live in houses or apartments.

Access to Health

Belgium has a mandatory national health insurance system managed by six private, non-profit health insurance funds. The main sources of funding are social security contributions from employees and federal government subsidies. Complementary health insurance, for example for hospitalization, is also available, but it represents only a small part of the Belgian healthcare system.

There are no specific legal provisions regarding Roma access to healthcare. **Roma access to health services is closely related to their residence status.** Roma nationals and Roma with residence permits can benefit from the same provisions as any other Belgian nationals. Roma EU citizens without residence permit are considered undocumented migrants. Specific rules for access to health services apply for asylum seekers who are mainly from the Western Balkans. The majority of Roma in Belgium are migrants, either EU citizens or third country nationals.

Table 1. Access to healthcare according to the residence status gives a clear overview of the situation in Belgium

	Residence status	Health coverage
Nationals	Belgian residents	Compulsory health insurance in Belgium Specific provisions possible for low income patients/social aid beneficiaries
	EU citizens - short term stay - without specific requirement	Authorized to reside for less than 3 months European health insurance card (EHIC) – if insured in the country of origin OR health insurance possible in Belgium for university students, employees or legal cohabitants of a person insured in Belgium
EU citizens – long term stay - required to register at the municipality of residence	During the first 3 months after the demand to register – “Appendix 19” status	Same rules as above, besides EHIC (only for short-term stay) AMU is not possible
	After the first 3 months, if the residence authorized – “Appendix 8 or “Appendix 8bis” case (residence permit)	Compulsory health insurance in Belgium Specific provisions possible for low income patients/social aid beneficiaries
	After the first 3 months, if the residence permit refused =>undocumented migrant	Urgent care is accessible (this is not emergency care), if a number of conditions are fulfilled, including absence of insurance in the country of origin
Third country nationals	Authorized residents	Compulsory health insurance in Belgium Specific provisions possible for low income patients/social aid beneficiaries
	Undocumented migrants	Urgent medical care is accessible if a number of conditions is fulfilled (unauthorised stay, medical need, financial hardship, address in Belgium)

Mediation Concept - Intercultural Mediators

Intercultural mediation in Belgium is defined as all activities that aim to reduce the negative consequences of language barriers, socio-cultural differences, and tensions between ethnic groups in health care settings. The ultimate goal is creating health care options that are equal for immigrants and native-born patients regarding accessibility and quality (outcome, patient satisfaction, respect for the patient’s rights, and so on). Intercultural mediation is a way to achieve

this by improving communication and thus acting strategically on the care provider/patient relationship. Intercultural mediation thus strengthens the patient's position, rendering care better suited to individual patient needs, while at the same time enabling the care provider to work more efficiently.

Besides bridging the language and cultural barrier, another important dimension of intercultural mediation is facilitating the therapeutic relationship between care providers and patients (Qureshi, 2011). According to Chiarenza (quoted in Pöcchacker, 2008), intercultural mediation also helps organisations adapt their services to the needs of immigrants.

History

The accessibility and quality of care for migrants and ethnic minorities (MEMs) suffers strongly from language barriers, socio-cultural barriers, possible interethnic tensions, racism, and discrimination. In order to offer MEMs equal access and quality of healthcare, it is necessary to take actions to minimize these obstacles, considering that the intercultural competences of healthcare institutions are often too limited to address these challenges on their own. This can lead to ethnic healthcare inequities.

The Belgian Government has decided to deploy intercultural mediators and not interpreters: mediators can not only overcome the language barrier, but also deal with other barriers such as unequal quality and access to healthcare.

In 1991, the first intercultural mediation program was launched for a five-year period, financed by various Flemish and Brussels ministries, and coordinated by the **Flemish Centre for Integration of Migrants** (Vlaams Centrum voor de Integratie Migranten), and – since 1992 – by **Foyer**.

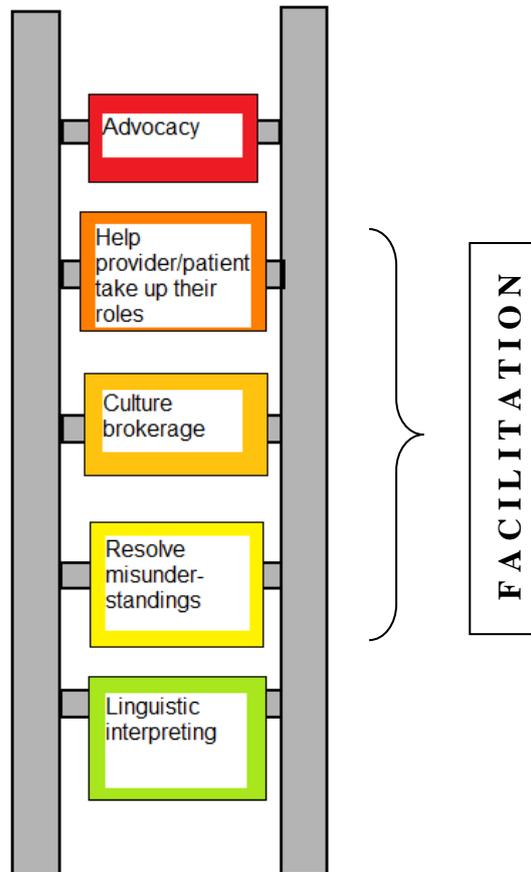
In 1999, thanks to the success of these projects, a specific program and related funding were established at the Federal Public Service Health (FPS), which progressively grew in importance. Currently, more than 50 hospitals benefit from this program. There are around 20 languages covered, and 100 intercultural mediators working all over the country. In this framework, there are various languages which can be of benefit to Roma migrants.

Besides carrying out on-site interventions, intercultural mediators also provide **video-remote intercultural mediation services** to hospitals, primary care centres, and medical services working with refugees. This solution allows for a countrywide coverage, even if a direct, on-site intervention is the preferred option.

Every year in December, FPS Health invites general and psychiatric hospitals to apply for intercultural mediation funding (for the positions of intercultural mediator and/or diversity manager). Applications must be submitted by January 31 of each year. The Intercultural Mediation & Policy Support Unit then reviews the applications and oversees the assessment and management of the intercultural mediation initiatives.

The responsible institution for mediation programmes in Belgium is the **Federal Public Service Public Health, Environment and Safety of the Food chain and RIZIV/INAMI**.¹ In addition, **Foyer**² (a non-profit organization founded in 1969) runs a very similar intercultural mediation program that employs – among others – Roma intercultural mediators.

Tasks of an intercultural mediator:³



Source: The so-called ladder-model, developed in Belgium, is a graphic representation of the different tasks of the intercultural mediator.

- **Linguistic interpreting:** the faithful and complete translation of an oral message from a source language into an equivalent message, taking into account content, form and purpose, in the target language.
- **Facilitation:** Many patients probably do not have the skills, a.o. because of a too low level of health literacy, to take on their role as an autonomous partner in the care providing process, and this independently from the language barrier. That is why intercultural mediators execute a number of other tasks that are more complex, have more risks and ask for more judgment on behalf of the intercultural mediator.

¹ www.intercult.be

² www.foyer.be

³ For a detailed description see: Verrept H & Coune I: Guide for intercultural mediation in health care. Brussels: FPS Health, 2016. Available on: www.intercult.be

- **Resolving misunderstandings:** the intercultural mediator signals possible misunderstandings to the conversation partners and also tries to solve them and in that manner redirect the conversation.
- **Culture brokerage:** the intercultural mediator will signal to the care provider and give more information when he feels the cultural differences are making communication and thus care providing more difficult.
- **Helping** the patient and care provider to take on their respective roles.
- **Advocacy:** the intercultural mediator is given the mandate to take initiative in asking certain questions or carrying out certain actions when it is necessary for the quality of care or the patient's interests. It is possible that the intercultural mediator might have to leave his impartial position in order to execute this task.

In Belgium, the intercultural mediator may either be someone who has completed a specific 3-year training program in intercultural mediation (at the level of higher secondary education), or holds one (or more) of a series of degrees that are enumerated in the royal decree on the funding of intercultural mediation. In practice, intercultural mediators have very diverse educational backgrounds. Some are nurses, (community) interpreters, psychologists, social workers, anthropologists, etc.

Intercultural mediators could be male and female. All of them have at least completed higher secondary education.

Intercultural mediators who do not have a master degree in interpreting or a recognized community interpreting certificate have to take the FPS Health **basic training module on community interpreting techniques**, taught by professors from universities which specialize in languages and/or translation/interpretation. The basic module comprises 72 hours of class (12 days of 6 hours of class once a month during a year).

During the **selection procedure**, intercultural mediator candidates are tested in a role play by the Intercultural Mediation & Policy Support Unit. The unit will afterwards tell the hospital whether the candidate is eligible for financing as an intercultural mediator. During this test a hospital staff member is allowed to be present. The hospital can ask for a written report of the test. If this is requested, an audio recording of the test can also be taken.

Reporting – each year, FPS Health asks the intercultural mediators and diversity managers to track all their activities during a period of one month by using a proprietary computer program. The diversity managers also have to submit a report on the activities developed.

Interventions via video are registered all year long by the intercultural mediators who execute them.

In addition, **meetings** with intercultural mediators and their managers are organized by the Intercultural Mediation and Policy Support Unit to monitor the program. **On-site visits** are also carried out to assess the quality of the intercultural mediators' work.

A report of the activities is then transmitted to the Belgian Minister of Health. A number of articles have been published on the program in Dutch, English, French, German, and Spanish.⁴

⁴ For a list, please contact us.

Intercultural mediators have to participate in at least 75% of the **supervision and training sessions** organized by the Intercultural Mediation & Policy Support Unit.

Case study

An eight year old Roma child has been admitted to the Emergency Room after his first epileptic seizure. When he is brought to a hospital room, he is very scared and hides behind his mother's back. He is making strange noises.

The intercultural mediator knows the family as a result of other interventions carried out for them. Another child in this family is being treated for a serious psychiatric disorder. The mediator also knows that the mother and father of these children are first cousins.

The MD and his assistants ask a number of questions to the parents on the epileptic seizure and the child's development, as well as on the other children in the family. The parents give very short and incorrect answers. The mediator notices that the parents are not very forthcoming with information on their children. The child is very scared and continues to make weird noises.

According to the parents, their child is in good health and has never needed a physician's help. The MD asks whether the child 'developed' normally. To this 'complicated' question, the parents reply that this is the case. They argue that the boy started to walk at a normal age and that everything is OK. Further questioning with the aid of the intercultural mediator reveals that the boy is unable to construct 'normal' sentences in Bulgarian and that his linguistic skills are very limited. It is also revealed that the boy was not toilet trained until the age of 6. The parents do not consider this to be abnormal. The father, however, points out that the son does not pay attention during meals and that he soils his clothes as a result.

On the bedside table, the mediator sees a plastic box filled with about 10 slices of bread doped in fruit juice. The son is hungry and the mother hands him 2 slices which he quickly puts into his mouth.

After the consultation the MD decides to further examine the boy.

The parents do not mention their daughter's problems and the fact that they are first cousins.

Personal story

S. was born in a small village in Turkey. Her grandmother was a traditional midwife and S. was invited to accompany her when she went to the homes of women who were delivering. S. was asked to wait outside the house during the actual delivery. When the child was born, her grandmother would come out of the house and deliver the good news to the family members waiting outside. S. was particularly touched by the joy and happiness of this very special moment. She then decided that she would also become a midwife.

When she was 8 years old, the family moved to Belgium. S. became a nurse. Witnessing an actual delivery, she was not feeling too well (she turned so pale that the delivering woman asked her whether she was ok ...). After this incident, S. decides that she will not become a midwife and that she will never have children.

S. starts working as a nurse on a paediatric oncology ward at a university hospital in Brussels. At the same time, she gets a master's degree in medical social sciences. After 8 years working as a nurse, she is contacted by a hospital in Antwerp. They are looking for an intercultural mediator to replace another mediator who is on maternity leave. S. is still working as an intercultural mediator more than 15 years later. She is driven by the urge to help and accompany patients during their hardest hours. Although the job is tough, she gets a lot of satisfaction out of it as patients are extremely thankful for her work.

Hans Verrept

Head of the Intercultural Mediation and Policy Support Unit

FPS Health, Safety of the Food Chain and Environment

Victor Hortaplein, 40 bus 10

1060 Brussel

Tel.: 00.32.(0)2/524.86.07

hans.verrept@gezondheid.belgie.be

BULGARIA - Health Mediator

Total population: 7,245,677 (Dec. 2013)

Main ethnic groups: Bulgarians, Turks, Roma

Official data: Roma population is 325,343

Non-official data: Roma are about 700,000 (8-10% of total population)

This discrepancy is due to the fact that many Roma self-identify as Turks or Bulgarians during censuses.

As of 2001, each Bulgarian citizen has to pay health insurance instalments to the National Health Insurance Fund (NHIF) in order to have access to health services. Each citizen has to choose a GP, who is the first level specialist assessing the health situation of the patient and eventually referring him to a specialist when and if needed. If the patient is insured, the doctor visit fee is about 1%⁵ of the minimum monthly salary. If the patient is not health insured, he has to pay about EUR 10 per visit. Health insured patients have the right to receive referrals from the GP and in this way they pay only the minimum to the specialist upon referral. Some (prophylactic) examinations are also paid by the NHIF.

Hospitalization costs per day for health insured patients are about 2% of the minimum monthly salary, and any medical exams or tests needed (depending on the diagnosis) are covered. Patients who are not insured pay the whole amount for any treatment received (hospital stay and examinations).

Patients insured by the state: all children between 0 and 18 years; pensioners; people receiving social benefits (usually not more than 9 months).

Groups facing problems with healthcare access:

- young people after 19 years who are unemployed and not enrolled at a university;
- long-term unemployed from all ages (the usual case of Roma);
- people working without an official labour contract (again, usual case in Roma communities);
- uninsured pregnant women – it is not possible for them to visit pre-natal prophylactic check-ups.

Possibilities for access to the health system in case of lack of health insurance:

- Emergency aid is free for everyone (but only in cases of real emergency).
- Delivery is free for all women regardless of their health insurance status.
- Since 2012, the state pays for one free check-up for women during pregnancy and one free laboratory examination (women have to choose when to do it – in the beginning or at the end of the pregnancy). However, practice shows that these check-ups happen almost exclusively in settlements where HMs work. A lot of preliminary communication with gynaecologists and laboratories is needed.
- A Decree of the Council of Ministers ensures hospital treatment of socially disadvantaged people through a special fund of the Ministry of Labour and Social Policy. Patients have to comply with several requirements concerning their financial state.

⁵ About 1.50 EUR in 2016.

Health Mediation

In Bulgaria, the health mediator model was launched in 2001 by “**Ethnic Minorities Health Problems Foundation.**”⁶ At that time, the pilot project “Introduction of a system of Roma mediators – an efficient model for the improvement of the access of Roma to health and social services” was implemented in the Iztok Quarter in the town of Kyustendil, and the first five health mediators were trained. Throughout the last 15 years the number of health mediators has been steadily increasing.

In 2007, the health-mediation programme became a national policy and the state began to allocate to participating municipalities an annual health mediation budget. In the same year, the health mediator profession was included in the National Classification of Professions and the government adopted an official job description for the position.

Health mediation concept

Bulgarian health mediation concept was introduced by the experts of Ethnic Minorities Health Problems Foundation and developed jointly with experts from Bulgarian Family Planning Association.⁷ Later on they formed the expert team of the National Network of Health Mediators, founded in 2007. The concept:

- The health mediator is an intermediary who **facilitates healthcare and social services access** for vulnerable/ isolated ethnic minorities. The health mediator is a **woman or man** who belongs to the local community and speaks its language.
- The health mediator is not an administrator, but a **field worker** who works actively to identify the most vulnerable and marginalized community members.
- The health mediator initiates communication with local health and social institutions and specialists, and offers them assistance.
- The main objectives of the programme are: a) To overcome cultural barriers in communication between Roma communities and local medical staff; b) To overcome the existing discrimination attitudes in the field of health services; c) To optimize the implementation of prevention programmes among the Roma population; d) Health education of the Roma and active social work in the community; e) Active social work with vulnerable Roma groups.
- The health-mediation programme is **an integration policy**. Typically, health mediators serve as an example among their community members. They are among the better educated in their communities, they have stable employment, and are working to improve the lives of others.

Responsible institutions:

National Council of Ethnic and Integration Issues at the Council of Ministers (National Network of Health Mediators is a member of the Council); Ministry of Health; **Ministry of Finance; Municipalities.**

The Association National Network of Health Mediators (NNHM) communicates with all listed institutions, monitors, and assesses the work of HMs on a voluntary basis. NNHM was founded in 2007 by health mediators, trainers of HMs, doctors, and public health experts in order to advocate for expansion of the HMs programme. In 2016, NNHM members were more than 190, and the

⁶ www.emhpf.org/index.php?lang=en

⁷ <http://www.safesex.bg/index.php>

organization is the **biggest public benefit organization in Bulgaria whose members are daily out in the field**, helping the most vulnerable groups of the population. NNHM implements projects in which HMs are key figures - aimed at better healthcare, better education, and qualification of HMs in different topics.

Job description

- To collaborate with GPs in obtaining high immunization coverage (search for non-immunized children, inform parents about vaccine-preventable diseases).
- To search for and identify people with disabilities and chronic illnesses, young mothers with many children, pregnant women that are not health insured.
- To assist illiterate people to submit documents to health and social institutions.
- To assist in the organization of prophylactic check-ups with mobile technique.
- To organize meetings for increasing the health culture and awareness within the community, including in schools and kindergartens (in cooperation with local and regional health specialists and institutions).
- To provide information and assistance to women who are willing to use IUDs or other contraceptive methods.
- To report cases of discrimination.

As a **municipal employee**, the HM is usually subordinated to a Deputy Mayor (smaller settlements) or the Director of Health and Social Activities Department.

HMs communicate with:

- GPs and other medical specialists
- Hospitals/ Emergency Units
- School/ kindergarten nurses
- Regional Health Inspectorates (28 in Bulgaria)
- Regional Health Insurance Fund
- Social services
- Child protection departments
- Regional Commissions for Protection against Discrimination
- Other social services providers and local NGOs

In Bulgaria the health mediator must:

- Be male or female.
- Have finished high school.
- Belong to a vulnerable community and speak its language (Roma, Turkish).
- Be computer literate - MS Office, Internet.
- Be communicative and well-accepted by the community.
- Be able to attend the 14-day initial training, annual HM meetings, and additional trainings/projects/meetings.
- Be certified by the Medical University after the initial training. Health mediators without this certificate may not be appointed in the municipalities.

The number of HMs working in each municipality generally depends on the number of Roma inhabitants therein, but also on the specifics of the community and the possibilities offered by the state budget.

HMs are field workers, but they have consulting rooms as well (in the municipality, in health/ social centres, in the Roma neighbourhood) where they receive clients, prepare reports, and use computer and internet for communicating with colleagues and obtaining new knowledge.

Ethical code

The Code addresses situations related to the interactions between:

- HMs within the Network;
- HMs and their superiors from the municipalities;
- HMs and Roma people;
- HMs and institutions and specialists in the health and social sphere.

Main principles:

- Loyalty and mutual aid between HMs in the Network.
- Restraining to provide material aid to Roma.
- Political neutrality - restraining from involvement in political actions (before elections the pressure on behalf of municipal representatives or political figures is often difficult to overcome).
- Keeping the confidentiality of the information obtained from Roma clients.
- Accountancy and transparency in monthly reporting.
- HMs are obliged to inform their colleagues for the periods when they will leave on vacation and will be absent from work (via the internet forum of the HMs).
- HMs must not use the relationship with clients for personal benefit.
- HMs must work to achieve better relationship between Roma and health and social institutions/specialists preserving the dignity of each of the sides and ensuring mutual respect.

Selection procedure

- The municipality sends a request to NNHM and justifies the need for a health mediator in a specific locality or community;
- NNHM prepares and sends the list with municipalities where HMs are needed to the Ministry of Finance and Ministry of Health;
- After the list is approved, each municipality opens a selection procedure for obtaining the documents of the candidates for HMs;
- The selection of the new HMs is divided in two stages: First, review of the submitted documents and second - interview with the Selection Committee. The SC includes representatives from the municipality; Regional Health Inspectorate; National Network of Health Mediators; General practitioner, representative of the community or local NGO.

Initial training

- 14 days.
- In Medical University - Sofia (or in Plovdiv).
- The training is provided jointly by the team of the Faculty of Public Health (Medical University) and experts of National Network of Health Mediators - Bulgaria.

- The training Programme includes 10 modules in 5 thematic fields, amounting to 240 hours in total.
- All newly trained HMs have to pass through an individual exam in the end of the training in order to receive their certificates.

Thematic Areas of the training:

- Health and social legislation,
- System of health services,
- Patient's rights and obligations,
- Health and health problems – basic health information, anatomy and physiology of the human body,
- Health and intercultural differences, history of Roma,
- Communication and advocacy,
- Professional role of the HM,
- Case work,
- Basic information of Infectious Diseases, Socially Significant Diseases, Hereditary disease.

Continuing education

After finishing the Initial HM training, NNHM in partnership with other NGOs and the Regional Health Inspectorates (district structures of the Ministry of Health) organize additional trainings for HMs on different topics. There is no state budget for continuing education, so the majority of the implemented projects are aimed at improving the knowledge and skills of the mediators on different topics.

For example, within the “Together for Better Health” project, we launched an expertise exchange - experienced health mediators visit the newly-trained ones to work with them in the field for few days, to help them prioritize their work, to assist them in the initial communication with local institutions, etc.

Some recent in-service training topics were:

- Sexually transmitted diseases and prevention of unwanted pregnancies (jointly with Bulgarian Family Planning Association);
- Obligatory immunizations and infectious diseases (Jointly with Regional Health Inspectorates);
- Carrying out of specific informational campaigns in Roma Communities on different topics (domestic violence, discrimination, etc.);
- Educating children on hygiene topics;
- Working with communities on discrimination issues.

Reporting and evaluation

Health mediators report their work on a monthly basis to the municipalities where they are employed. Up until 2016, there were different reporting templates depending on the municipality and also – a template for monthly report proposed by NNHM and used by many of the HMs. In addition to the report, the HMs were trained to describe in a simple template specific cases from their work (cases of individual clients and cases of group work in the community).

As of April 2016, a new NNHM reporting form was introduced, which aims to standardize HM reporting throughout the country and to provide basic quantitative data needed for assessment of

their work and impact. The new reporting form is a table where the HM marks the different types of activities (assistance for vaccinations and prophylactic check-ups, work on health or social cases, accompanying clients to institutions, filling in documents, carrying out health-information events in the community, etc.).

Twice a year all HMs have to summarize and report their activities to the network which issues a yearly report. There is no evaluation or monitoring system implemented by the state.

“S.V. is 25-years old woman with mental retardation – she is mother of 4 children and now she is pregnant in the 4th month. Her youngest child is 10 months old. The children are not recognized by the father – he is 30 years old man but he doesn’t pay any attention and doesn’t care for the children.

One of the children has been adopted because the mother left him in an institution after delivery. Now S.V. is a client of the Social services, Child Protection Department and Centre for Community Support in Stolipinovo (CCS).

The colleagues from CCS asked me to join their efforts to work with this mother – they needed my assistance to motivate her to place IUD after birth – for her it is a problem to understand what we are trying to explain and in addition – she doesn’t speak Bulgarian language well. This is part of my tasks – to explain her everything in her language (Turkish).

Together with the colleagues from CCS we agreed that we should try to motivate the mother and her mother to keep the baby that is going to be born. I go often to the house of the mother and speak with her – we discuss the future needs of the baby and the CCS undertook the engagement to ensure at least the basic needs after the delivery – pampers and clothes that we succeeded to gather among colleagues.

I am visiting the family often and I continue to work with the mother and with the grandmother – we are waiting for the new baby to come – and we expect the placing of IUD afterwards.

This case is important for me because it shows that several institutions and me, in the position of Health mediator, can work together and achieve results. In this way we, as providers of services, are satisfied that visible results are obtained and our clients – the people from the local community – have the sense that many people care for them. We could not do our work – help the people – if we don’t act as a team.” Angel Mihaylov, HM, Plovdiv municipality.

A. is 32 years old man, born in Roma quarter in Bulgaria. He is married with two children.

Education: Graduated all semesters at Business Administration in European College for Economics and Management (final exams forthcoming).

Languages: Bulgarian, Turkish and English.

Occupation: Health mediator since 2013 in the biggest Roma neighbourhood in Bulgaria - Stolipinovo, about 40,000 inhabitants.

Hobbies: computer games and rap-music.

Childhood and family:

Angel says he is a lucky man because in his childhood he wasn't raised in the Roma neighbourhood. According to him the environment in which people grow up determines how a person will evolve. He has a sense of humour and his colleagues describe him as a kind and responsive person.

"Unfortunately my wife and my parents are not educated (they have elementary education) – but my parents have realized how important the education is and because I was the only child, they succeeded to ensure my education."

About job:

Before the training for Health mediator – Angel worked for 10 years as an outreach worker in Programme "Prevention of HIV/AIDS" - Bulgaria (The Global Fund to Fight AIDS, Tuberculosis and Malaria).

"My interest towards the Health mediator's profession was caused by the fact that many colleagues in HIV/AIDS program worked as HMs and they were talking about their work and the services they provide. This profession seemed to be interesting and perspective. Unfortunately, I had to wait until 2013 to have the opportunity to participate in HM's training and I succeeded to pass through the final exam. I was very enthusiastic about this work and I did my best to achieve good results. The profession Health mediator gave me more contacts and friends and also - more opportunities to help people through the services provided by Health mediators."

In the beginning of 2016 Angel started working for Youth Centre - Plovdiv where he works with people between 15 and 29 years. The best of it is traveling around Europe and the exchange of experience with other people who are working on the field.

"As a HM I succeeded to gain authority within my community. Now I am an example for the younger and active youths – an example that education makes sense. Of course, there are also people that could not be helped but when you treat them as human beings and show the needed respect towards them they appreciate this and are grateful."

About motivation:

Health mediators are positive examples among people in the communities they originate from. They are educated, they have a job and they are respected because of what they do every day.

"My family and the desire to provide better opportunities and future for my kids is what keeps me motivated. I like my work in healthcare. I have worked in this sphere all my life. The only thing I don't like is the payment."

Important things in life:

In Bulgaria the Health mediators are fighting against stereotypes and discrimination. One of their missions is to show to the majority of the population that Roma people are different and they should be respected as human beings and as individuals according their individual actions. Angel defines stereotypes as something that cripples people's future. For him looking at the people through stereotypes doesn't allow to see them as a potential that could be developed. In his opinion, through stereotypes we always look for the bad side of a group and usually what we see turns out not to be true if we could look more closely and individually.

A discriminative attitude on behalf of people who doesn't know him as a person, only because of his skin colour, occupation or neighbourhood is very insulting for Angel.

Because of this he concludes: "Underestimation is something that I never want to see in front of me!"

www.zdravenmediator.net

info@zdravenmediator.net

prof. Ivaylo Tournev (Member of the Managing Board of the National Network of Health Mediators)

itournev@emhpf.org

Diliana Dilkova (Member of the Management Board of National Network of Health Mediators)

d.dilkova@gmail.com

Vanya Ivanova (expert, National Network of Health Mediators) abadjieva.ivanova@gmail.com

SLOVAKIA - Roma Health Mediator

Total population: 5,426,252
(dec.2015)

Main ethnic groups: Slovak,
Roma, Hungarians

According the official data,
Roma are **105,738** people.

In Slovakia, **about half of the Roma population is integrated into the overall population, while the other half live in so-called Roma settlements.** As in many countries in the region, Roma settlements in Slovakia are often geographically isolated and characterized by a lack of infrastructure, hygienic amenities, and social and health services. Due to these and other factors, employment rates, educational attainment, and health literacy are especially poor. Poor living conditions and socioeconomic exclusion influence the health status of the settlements' inhabitants, and Roma living in these settlements are among the population groups most exposed to health-related risk factors.

The health situation in Roma communities is characterized by a high frequency of illness, chronic and infectious diseases, permanent reduction in physical and mental performance, repeated ill-health - particularly in ever-growing isolated Roma communities, and low life expectancy (according to estimates - about 15 years lower than in majority population communities nearby).

Preventing the occurrence of epidemics and intervening in their acute occurrences is - according to domestic and international experience - only possible with the help of a long-term and systematic health promotion program based on work performed by field healthcare assistants who conduct health education, training, consultancy. Field healthcare assistants provide services to a network of health care providers and public health with population groups most at risk.

Given the above situation and the inevitable need for a speedy resolution, thanks to the joint efforts of institutions from two sectors - the NGO Platform for Supporting of the Health of Disadvantaged Groups and the Ministry of Health, as of 1 October 2014 the first system solution aimed at implementing a national long-term health education program in the environment of excluded Roma communities in Slovakia with the extension of **Healthy Communities project to a national level.**

Public health insurance is financed through redistribution of public resources on the basis of premiums paid by all participants into the system, through health insurance companies. Based upon current law, the mandatory health insurance, makes it an obligation to pay premiums for health insurance, i.e., personal scope of health insurance.

An insured under the compulsory public health insurance is any person who:

1. Has a permanent residence in the Slovak Republic, and has not been residing in another country for a period of more than six months for the purpose of employment, business, or long-term stay
2. Is not a resident of Slovakia, but at the same time:
 - a) is employed or conducts business in Slovakia

The **only possibility for access** to the health system in case of lack of health insurance is emergency medical care - it is free for everyone, but only in cases of real emergency

- b) is a refugee
- c) is a foreign student
- d) is an alien detained or imprisoned in Slovakia
- e) is a dependent of an insured person who was born in another EU Member State
- f) is a minor alien without a legal representative, assigned to a housing facility (where healthcare is provided) by a court of law

Groups with healthcare access problems:

- long-term unemployed of all ages;
- people working without an official labour contract;
- elderly people
- marginalized Roma communities
- young people older than 18, who are unemployed and not enrolled at a university⁸
- remote/rural communities
- people with disabilities
- homeless people
- single parent families
- social – economic deprived families
- drug users
- sexual minorities

Ministry of Health of the Slovak Republic and Healthy Communities, n. p. o. realise the national Health-Mediation Programme in Slovakia.

In 2003 a non-governmental organization, **The Association for Culture, Education, and Communication (ACEC)** launched the Healthy Community programme in 11 settlements. The project quickly began attracting the attention of domestic and international organizations. Between 2003 and 2012, it was financed by private sources – a model which allowed a lot of flexibility in implementation of processes while trying to find the optimal model for realization.

In 2007 the Public Health Authority of the Slovak Republic developed the Programme to Support the Health of Disadvantaged Communities from 2007 to 2015, to address the needs of Roma and other disadvantaged groups.

It turned out that the Healthy Community programme corresponded fully to the objectives of the new governmental programme. From 2007, the project has been the most extensive and longest running effort focused on Roma health improvement and health awareness in segregated Roma communities in Slovakia.

In 2012, ACEC initiated the **Platform for Support of Health of Disadvantaged Groups (PSHDG)**. Active members of this organization are Association for Culture, Education and Communication, Association of Field Health Assistants (ATZA), Society of General Practitioners in Slovakia (SVLS), WHO Office in Slovakia, Glaxo Smith Kline, Union – insurance company, the Office of the

⁸ Enrollment at school is mandatory till the age of 16. During this time, health insurance covered by state. From this age on, people without continuation of their studies lose the state coverage of insurance, with the exception of those registered in the Office of labour, social affairs and family as a job seeker.

Plenipotentiary of the Slovak Government for Roma Communities, Emergency Medical Services Operation Centre (OSZZS), Open Society Foundation, and others. The activities of the PSHDG aim to create a complex model for supporting health improvement among disadvantaged communities, especially inhabitants of segregated Roma settlements. These activities are mostly focused on advocacy, promotion and increasing of awareness of health of disadvantaged groups, educational and research.

On October 7, 2013 the project was rolled out nationwide. One year later, in October 2014, the partnership between the PSHDG and the Ministry of Health was created, and eventually led to the founding of the Healthy Communities NPO.

The Healthy Communities non-profit organization provides, according to its statute, general community services in the area of creation and protection of the environment and public health with an emphasis on improving education levels, skills, awareness, and protection of health. The main goal of the organization is to further systemize a program of health awareness in disadvantaged communities on the whole territory of the Slovak Republic through implementation of the National Program Healthy Communities, source more human resources from segregated settlements, and increase employment.

Between 1 October 2014 and 31 December 2015, Healthy Communities implemented the national Healthy Communities project, financed from EU funds - Operational Program Employment and Social Inclusion.

The project was carried out in accordance with the Roma 2020 Integration Strategy of the Slovak Republic and the international strategic documents of the European Union (Europe 2020 - Strategy for Smart, Sustainable and Inclusive Growth, recommendations of the Council of the EU, etc.)

The Healthy Communities project focuses on **Roma Health Mediators (RHM) and their Coordinators**. In Slovakia, RHMs carry out various activities that can differ significantly depending on given demographic differences and epidemiological situation in respective locations. For example, in locations with high rates of teen pregnancy, RHMs focus more on sexual education, planned parenthood strategies, raising awareness about the necessity of regular gynaecologic examinations, post-natal mother visits, inviting mothers to neonatal clinics, etc. In other cases, the RHM is focused on increasing awareness about hygiene and environmental factors affecting the health of inhabitants of project locations. RHMs collected samples of water and soil and took them to research facilities for analysis. RHMs and their coordinators also organized big clean-ups in the settlements, transport of collected municipal waste, and clean-up of water sources in some locations. They also perform many of their professional duties after the regular work hours and on their personal time, because their work has become their life mission.

Slovak RHMs

- Gender: male or female
- Education: completion of compulsory education is a requirement, completion of lower secondary or full secondary education (advantage).
- Language skills: Slovak language - required, knowledge of the language spoken in socially excluded communities (Roma / Hungarian).

- Work experience: experience in organizing activities in the assigned area, field work in health promotion or social work.
- Community relations: the acceptance and respect of the local community and local government officials, permanent presence in the community is a prerequisite; permanent or temporary residence in the municipality.
- Other requirements: motivation to work with the inhabitants of segregated and separated Roma settlements, self-discipline, credibility, trustworthiness, sense of responsibility, moral qualities, good communication skills, no serious offense committed.

Selection Procedure

Information about job opportunities are published on official websites and other support channels (mayors, local players such as social field workers, local NGOs, etc.). The **selection committee** is composed of representatives of Ministry of Health, Office of the Plenipotentiary for the Roma Communities, Healthy Communities NPO, WHO Office in Slovakia, Ministry of Labor, Social Affairs and Family and Platform for Support of Health of Disadvantaged Groups.

Selection of employees is based on results of **personal interviews** (done by management) and on information from application materials submitted by the applicants (CV, questionnaire focusing on experience and motivation, diplomas, a medical affidavit).

The main criteria for the selection of individual candidates for the position of Roma Health Mediator are motivation, experience, references and recommendations, and educational attainment.

Education and Training

Educational activities are based on a course by the Association for Culture, Education and Communication, accredited by the Ministry of Education. The training course is 88 hours in total for one year, and it is divided into progressive modules.

Thematic units include:

- The healthcare assistant's role.
- Basic communication skills regarding Roma community work.
- Basic human biology.
- Basic epidemiology of diseases.
- Specialized social health counselling.
- Caring for pregnant women and new-borns.
- Regular first aid training.
- Awareness raising activities and advice on health education in schools.
- Basic specialist advice on reproductive health.
- The healthcare assistant's work methodology.
- Leadership, management and building project teams in professions focused on the Roma minority.
- Low-threshold programs and activities for families on prevention.
- The social networking of assistance systems and institutions.
- Psychological aspects of conflicts.

Challenging work in the field requires continuous education and strengthening of motivation.

Health mediators and coordinators are the crucial success factor. Their continuous education, personal and professional development are one of the specific goals of the project. Creation and enhancement of this social capital leading towards networking with cooperating professions and institutions will potentially bring a multiplication of positive impact of project activities. The main goal of the project - improvement of health, increased level of education and higher rate of employment in marginalized Roma communities is delivered through a methodically uniform and regular education, employment and systematic performance of outreach activities. Each year, an RHM mediator has to pass three mandatory two and a half day training sessions; In addition, 29.9% of RHMs and 52% of coordinators continue in further education (voluntarily). Their employers actively support employees to further develop their qualifications.

Job descriptions

Roma Health Mediators (RHM):

- Spreading health information among disadvantaged Roma communities living in segregated and separated Roma settlements.
- Support communication between inhabitants of Roma settlements and healthcare providers.
- Supporting increase of level of individual responsibility for one's own health among the members of the community.
- Supporting access of the community to healthcare; informing people about prevention, provisions of healthcare and health insurance and about patient rights and obligations.
- Cooperation with medical doctors, health workers, pharmacists and helping professions.
- Inviting, scheduling and accompanying clients to health examination appointments
- Inviting, scheduling and accompanying clients to vaccination appointments and spreading awareness about the importance of vaccination.
- Cooperation on identifying risk factors and needs related to the health of the community.
- Cooperation on information exchange and sharing experiences with social field workers, Roma teaching assistants, non-governmental organizations helping Roma communities, and Office of the Plenipotentiary of the Slovak Government for Roma Communities.
- Cooperation with schools to increase health awareness among students.
- Cooperation with bodies and institutions of national and local government and enabling their communication with clients.
- Raising awareness about infectious diseases and their prevention, awareness about personal hygiene.
- Organization of public events focused on increasing awareness on health-related topics.

Coordinators of Roma Health Mediators:

- Preparation and implementation of health support programs in disadvantaged Roma communities.
- Supervision and monitoring of work and fulfilment of RHM tasks.
- Communication between inhabitants of Roma settlements and different healthcare providers.
- Spreading the basic health awareness in the community together with RHMs.
- Informing the community about prevention, provisions of healthcare and health insurance, about patient rights and obligations.

- Regular monitoring of the community – observing the situation, collecting data and research on health awareness.
- Interim evaluation of the program effectiveness.
- Cooperation on information exchange and sharing experiences with social field workers, Roma teaching assistants, non-governmental organizations helping Roma communities, and Office of the Plenipotentiary of the Slovak Government for Roma Communities.
- Cooperation with Office of Labour, Social Affairs and Family - especially with departments of child protection and social custody while working on measures enforced by these departments.
- Cooperation with Public Health Office workers while working on interventions in the field.

Roma Health Mediators and Coordinators have had a professional code of ethics since 2013, based on the following principles:

- Protection of human rights and dignity of clients.
- Confidentiality, maintain of secrecy.
- Help to all who need it.
- Professional responsibility over personal interests.
- Maximum utilization of skills acquired during the training.
- Services within job description, no financial support.
- Leading to consciousness of responsibility for their lives and lives of their loved ones.
- Participation in all trainings and coordination meetings.
- Maximum effort to improve the quality of life of their clients.
- True, accurate and understandable information, without manipulation.
- Provision of assistance, only if they do not endanger other or oneself.
- Knowledge of the rights and obligations of patient, always acts in the interest of client.
- Respect of privacy.
- Assistants and coordinators solve problems face to face. Slander is unacceptable.
- Their behaviour is an example for their community.

Reporting and Evaluation

A Roma Health Mediator records all his/her daily activities carried out in his/her location in the RHM Logbook. The logbook is an important document in which are recorded all the activities carried out during the working hours. The Roma Health Mediator's Logbook must be always available for inspection carried out by the Coordinator of Roma Health Mediator. Mediators also record all their activities/interventions in a special form divided by categories (cooperation with doctor, schools, vaccination, and health check – ps). The RHM Coordinator collects reports of RHMs in the given geographic area and submits them to the NGO headquarters on a monthly basis. Management evaluated activities regularly in order to optimize the set of processes in the field.

Example of RHM working day:

- The mediator starts the day by reporting to coordinator, then he goes to visit a medical facility, where he picks up invitations from a doctor, then he visits another doctor, to whom he reports values of patients' blood pressures, measured in domestic environment. He visits the next doctor to inquire about how to obtain adjustable bed for patient.
- On the way to the settlement, he picks up medicine for pensioner, visits a client in the settlement and delivers him a message from a doctor. He measures his clients' pressure, orders a patient for another term at the doctor, visits a mother, whose child is to be released from hospital that day. He performs rehabilitation exercises with another client (after previous training by rehabilitation nurse – convenient in winter)
- He goes to school to settle a term for meeting with younger pupils, consults with teacher the families with health issues (e.g. lice)
- He visits the families, where he lends a comb to mother to comb out the children's lice, or he/she does it on his/her own.
- He makes necessary administration (time sheet) and reports to coordinator.
- At night he goes to treat injury and call an ambulance.

For example Trebišov:

Coordinator's statement: "The biggest success in the locations of my group is that the vaccination rate of children grew, our clients go to preventive examinations to GPs and dentists more often and they care about their health more. We often cooperate with the Regional Public Health Office in Michalovce and Trebišov. Mayors of every town and village where our RHMs work like our cooperation and our cooperation with field social workers is also very good. Principals and teachers at local elementary schools also like the work of our RHMs very much. Therefore, we are planning more awareness activities in schools."

Two of the Trebišov RHMs prevented spread of infectious hepatitis A by their self-sacrificing work. By the end of 2015, 85 clients were sick with jaundice. Regional Public Health Office in Trebišov wanted to close local elementary school that is only attended by Roma children. RHMs achieved the decrease of this infectious disease. RHM together with Coordinator worked closely with the RPHO in Trebišov- they invited clients for blood and urine samples collection for disease identification, spread awareness and accompanied clients to vaccinations against jaundice.

On the occasion of World Water Day, Coordinator and RHM collected 24 samples of water for detection of nitrates. RPHO in Michalovce analyzed the samples.

RHM in the Trhovište location increased vaccination in children and his clients started going to regular check-ups. His awareness activities at Trhovište elementary school were very well received by the teachers.

Two RHMs of the group decided to continue their studies. One of them enrolled in the vocational school in Sečovce (masonry) and another one at the vocational high school in Bardejov (advertising graphics).

Mr. Jozef Gurgul', age 61

Low light of flashlights and candles, lively entertainment behind the door. While most of the inhabitants of the town of Iňačovce near Michalovce celebrated payment of social benefits, a dramatic fight for life took place in the deteriorated apartment complex on the outskirts of the village over a year ago.

Former tractor driver Jozef Gurgul' (60) helped to give birth to a healthy baby in third-world-like conditions.

Jozef himself does not have any special medical education.

Twenty-five year old Roma woman Veronika gave birth to her fourth child in a small room without electricity with his help. He was only assisted by the family and a rescue worker on the phone. Fear and anxiety were overcome by baby's crying after several minutes, Gurgul' quickly ligated umbilical cord with torn linen, cleaned baby's face with water from a washbasin and wrapped her in a sheet, and handed her to her mother.

Veronika, despite four pregnancies had no insurance card, maternity book or sense of responsibility. She ignored preventive examinations during her pregnancy.

He did not give up

Jozef has lived in the settlement with his mother and two brothers since he was born. His mother was trying to make some extra Money by working on farms. She died when Jozef was in high school and his aunt took the responsibility for him. He ate his meals in the dormitories in Michalovce, and his clothing came from containers.

After school he got a job at a local agricultural cooperative, where he worked as a tractor driver. He managed to save up for a house, marry and raise three sons. Two of them are cooks, and one is a medic.

Childbirths, syphilis and mumps

Since October, Gurgul' started working for Healthy Communities project under non-governmental organization Platform for Support of Health of Disadvantaged Groups and Office of the Plenipotentiary of the Slovak Government for Roma Communities.

Veronika's case is not exceptional for him. There is a 100% unemployment rate among Roma in Iňačovce and even today there are five pregnant women in the settlement. Aside from assisting with childbirths, he helps with treatment of syphilis and mumps. In spite of problems in the settlement, he is not giving up: "I'm trying to do my work the best I can."

There are around 700 inhabitants living in Iňačovce- about a third of them are Roma. There is a lack of trash cans and the trash is usually thrown out of a window.

The hospitalizations of newborns with pneumonia and bronchitis are a regular thing, The locals suffer from lice and scabies. An unusual experience for Gurgul' as a Roma Health Mediator was

being invited to Bratislava. They asked him to help a Roma woman suffering from syphilis who was deported from England.

“She was taken there by her significant other and she worked as a prostitute, then they sent her home and called me to take her to the hospital in Michalovce”, says Gurgul smiling. For his work, he was awarded with Roma Spirit award in Act of the Year category in December 2014.

www.zdravekomunity.sk

Mgr. Michal Kubo, director - Healthy Communities, n.p.o.

michal.kubo@zdravekomunity.sk

www.zdravekomunity.sk

Mgr. Magdaléna Rothová, director – Association for Culture, Education and Communication (ACEC), executive secretary Platform or Supporting Health of Disadvantaged Groups

rothova@acec.sk

www.acec.sk

SPAIN

Spanish Roma are entitled to healthcare by the same legislation that entitles the rest of the Spanish population. Laws applied for foreign EU and non-EU Roma are those addressed to the foreign population.

The Spanish National Healthcare System was public, universal, and free thanks to Law 16/2003 of Cohesion and Quality of the NHS. However, in 2012, the government approved Royal Decree Law 16/2012 on urgent measures to guarantee the sustainability of the NHS. This entailed an entitlement restriction as it eliminated the concept of universal healthcare in favour of healthcare insurance. Only the following groups are eligible for healthcare insurance: (a) workers affiliated with the Social Security System; (b) pensioners of the Social Security System; and (c) recipients of jobseeker's allowance and unemployment benefits.

Total population:
46,815,916
(National Census of 2011)
There are Spanish Roma and foreign Roma (e.g. from Bulgaria, Romania, Portugal).
Spanish Roma are not officially recognized as an ethnic minority in the country.

Spanish Roma and foreign Roma from EU countries who do not belong to any of these groups can be entitled to NHS if (a) they prove their income does not surpass established limits; and (b) they pay a monthly rate to access the NHS as a health insurance company. This decree does not apply to: (a) minors, (b) emergencies, and (c) pregnant women.

Since Spanish Autonomous Communities have competencies in health and primary care, some (e.g., Andalusia and Catalonia) have developed strategies to ensure access to healthcare for those excluded by the decree.

The decree worsened the low socio-economic conditions of most Roma, especially foreign born Roma, and has led to a universal increase in health problems. Pharmaceutical co-payments are not an option for Roma living below the poverty line, even if they are entitled to it. Cutbacks to NHS's material, human, and economic resources, as well as the privatisation of services have had dire consequences (e.g., closure of PHC and specialised services, staff shortage with lack of cultural sensitivity and/or burnout and work overload, co-payments). Also, applying for a health ID card involves bureaucratic procedures and additional documentation that amount to further barriers for the Roma to obtain entitlement.

The concept of mediation entails the existence of conflicting realities but also of people, groups, or communities who need support "from third-parties" to improve their relationships. In this sense, this concept is suitable to the Roma reality and their interactions with the majority population.

Although different models of mediation exist, the one best adapted to the social and health intervention with the Roma is social and intercultural mediation. This is an intervention of third parties in and on significant multicultural situations. It is oriented to acknowledging the **other**, and the reconciliation of parties, communication and mutual understanding, learning and coexistence, conflicts regulation and institutional adaptation, between ethno-culturally diverse social actors and institutions.

Mediation must assume a bridging role in order to remain fair and impartial, and to avoid over-identification with one of the parties. However, in regard to Roma, its main function is more akin to a professional peer worker. This suggests that health mediators can be called **health agents** who assimilate social and intercultural mediation as one of their functions and work methodologies.

In 2005, when the **State Council of the Roma People** was founded, very few Roma organizations had health related issues among their objectives. The creation of the council strengthened Roma organizational movement, thus contributing to important areas of governance - including health - by allowing mutual knowledge and exchange of experiences between organizations.

The starting point of the Health Workgroup from the State Council of the Roma People was an initial diagnosis of Roma health status based on a National Survey developed under a collaboration framework between the Spanish Ministry of Health and Consumer and Fundación Secretariado Gitano (2003-2008).

One of the first tasks of this Workgroup was to participate in the analysis of the Roma health situation (November 2007) in order to propose the Action Plan for the Development of the Roma Population 2010-2012 and the later National Roma Integration Strategy in Spain 2012-2020. Both documents reflect the importance of Roma participation.

In this working context, Roma organizations have been gradually including health interventions among their objectives, and have begun collaborations with different health administrations to improve Roma health. In this sense, the Roma health mediation program is bound to contribute to health equity and empowerment.

Equi-Sastipen is a network composed of 19 Roma organizations and federations created and coordinated by the UNGA association, which started in 2010 a joint effort to promote and reinforce actions in health. This network was founded with the goal of sharing and growing, training intercultural mediators in the health domain, increasing Roma community knowledge among healthcare professionals and undergraduate students, as well as using all their experience at local interventions.

The network also works as a big advocacy engine for interventions within the Roma community done by Roma organizations as well as from competent administrations (e.g., Equi-Sastipen actively participates in the coordination of the Health Workgroup from the State Council of the Roma People). All this enables Roma organizations and communities to participate in the decision making processes which affect their health.

Associates

- Asociación Gitana UNGA (Asturias) – Coordinadora de la red
- Federación de Asociaciones Gitanas de Cataluña FAGIC
- Federación de Asociaciones Gitanas de Aragón FAGA
- Federación Autonómica de Asociaciones Gitanas de la Comunidad Valenciana FAGA (Alicante)
- Federación de Asociaciones Gitanas de Navarra Gaz Kaló
- Nevipen Ijito Elkartea (Vizcaya)
- Federación Española del Pueblo Gitano (Madrid).

- Asociación de Mujeres Gitanas Alboreá (Madrid)
- Federación Andaluza de Mujeres Gitanas FAKALI
- Asociación de Mujeres Gitanas Universitarias AMURADI (Andalucía)
- Federación de Asociaciones Gitanas Extremeñas FAGEX
- Asociación de Gitanos de Hoy (Cantabria)
- Asociación de Mujeres Gitanas Sinando Kali (Jaén)
- Asociación Promoción Gitana de La Rioja
- Asociación Barró (Madrid)
- Asociación Romi Serseni (Madrid)
- Federación Regional Gitana de Asociaciones de Castilla-La Mancha
- Federación Nacional de Asociaciones de Mujeres Gitanas Kamira
- Asociación FAC CALI (Madrid)

Profile of the healthcare mediator

- To be conscious of the intern diversity of the Roma community in regard to their customs, values, identities, social and economic situation, etc.
- To be a positive referent for the community.
- To have the capacity of creating trust relationships with the Roma community and the rest of the population.
- To have capacities to work in groups.
- To have capacities to mediate in conflicts.
- To have basic knowledge on the healthcare system and positive attitude towards it.
- To have proper reading and writing competences.
- To have basic knowledge on internet and computers.
- To have a positive attitude towards continuing education.
- Previous educational training is positive evaluated.
- Previous experience in social intervention is positive evaluated.
- To be Roma origin, since peer work is implemented among other methodologies.

Tasks of the health/intercultural mediator

- To facilitate the communication between healthcare professionals and culturally diverse users, such as the Roma.
- To advise healthcare services users in their relationship with professionals and public/private services.
- To advise professionals in their relationship with culturally diverse users in order to achieve and effective attention of their needs and interests.
- To promote access to services and guarantee attention to culturally diverse population in equal conditions than the rest of the population.
- To provide personal support to users.
- To promote community mobilization.

Selection procedure

Selection procedures are very different depending on the region and the Roma organization in question. The Equi-Sastipen-Roma network has agreed on a list of criteria to select health

mediators or health agents.⁹ From the network experience, it is much recommended to involve someone from the Roma organizational movement in the health mediation process. This is important in order to assess the aspects closely related to their position within the Roma community and their capacity to establish trust relationships. Also, the participation of a healthcare professional is desirable in order to assess other technical aspects of the mediation process.

Initial training

In Spain, there is not an initial and regulated training required in order to practice health mediation. In this sense, experiences are very diverse, considering each territory and organization.

The Equi-Sastipen-Rroma network has developed a reference manual¹⁰ to promote health within the Roma community. This manual intends to compile basic contents on the training of health mediators who want to work for health promotion in Roma organizational movements.

Continuing Education

The Equi-Sastipen-Network, in collaboration with the Universidad Pública de Navarra, has developed an on-line training course titled "Curso universitario de especialización (on-line) en promoción de la salud con la comunidad gitana" (on-line university specialization course in health promotion in the Roma community"). It was developed in 2014, and consists of four ECTS credits. Various Roma professionals who work in health projects in Roma organizations throughout Spain have participated in this course.

The annual meetings organized by the network also serve as continuing education sessions. One part of these meetings is always dedicated to address problems related to Roma health (conceptual or methodological) that can be useful for the daily work of the network's organizations. For example, smoking prevention, positive parenting, program evaluation, Roma impact in health policies, have all been topics discussed in the past.

Equi-Sastipen-Rroma health agents can also complete their training through external training offers not organized by the network. As an example, some health agents belonging to the network's organizations have obtained the professional degree of Specialist in Social Integration. In some Spanish Autonomous Communities, the health agents have the possibility to complete this professional degree without having previous academic degrees but with sufficient professional experience in social work instead. Another example is that some members from the network have obtained a 30 ECTS Private University Degree in Social Intervention with the Roma Community at Universidad Pública de Navarra.¹¹

Ethical code

- To reach out to prevent conflicts and look for opportunities to improve coexistence.
- To actively listening to the different parties.
- To have an openness attitude towards all stakeholders.
- To know the right position of the mediator between the parties.

⁹ Please, see section "Profile of the mediator".

¹⁰ www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/Equi_sastipen_rroma.pdf

¹¹ www.unavarra.es/fundacionuniversidadsociedad/formacion/titulos-propios-de-la-universidad/diplomado-en-intervencion-social-con-la-comunidad-gitana

- To be clear on the clarity of their role as a bridge in the access to resources or the resolution of conflicts. A mediator is not a manager of resources.
- To have a collaborative relationship and complementary role to other professional figures.
- To not hide conflicts.

Reporting and Evaluation

The Equi-Sastipen-Rroma has agreed on a variety of tools to evaluate the design, processes, and results of health mediation. These tools are employed by each organization of the network in the implementation of their programs, and are assembled within the networks' manual for the promotion of health in the Roma community.

The heterogeneous nature of the network (i.e., according to the size of its organizations, to the territory, to the degree of programs developed, etc.) hinders a joint evaluation of all the programs developed by the network. However, Equi-Sastipen-Rroma organizes at least two annual meetings in which, among other objectives, function as a qualitative assessment of the processes and results of all the programs implemented.

Antonio is a 50 years-old Roma male who lives in a rural area of Asturias, in the North of Spain. He is married and has one child. He owns the degree in compulsory secondary education.

He wanted to be a mediator because, since he can remember, what he likes most is dealing with people, listening to others, and trying to motivate them to overcome dire situations.

Approximately 25 years ago, he started working as a mediator after doing a course on social mediation provided by a Roma association of the area. Within the field of mediation, he specialized in substance abuse. He worked for 5 years in a renowned foundation against drug abuse, thus being the first Roma therapist in this field.

He has been working for 25 years in the Roma association UNGA as social and on the street mediator, as a drug abuse therapist in the program AKERANDO ROM, as health mediator in the program AUPRE aimed to reduce health inequities among the Roma community in Asturias, and he has also worked as health mediator in hospital facilities.

The Equi-Sastipen-Roma network deals with a case of a 6 year-old boy of Roma origin with high school absenteeism rates. The teachers and the director of his school are very worried since they never get to speak with their mother. They think that, maybe, the Roma organization—through the network—can provide a mediator to contact their parents and find out what is the reason for the child to not attend to school.

A mediator starts working on the case. He managed to reach the family and learned that the boy's mother suffers severe anxiety episodes what makes her afraid, that is why she is anguished to send the boy to school.

After some informal interviews with the mother, the mediator proposes to her the possibility of going to a healthcare centre to talk to a psychiatrist. At first, she prefers the mediator to talk to the psychiatrist and so she gives permission to the mediator to provide information on the case. After the appointment between the mediator and the psychiatrist, the women still feels reluctant to go by herself. However, she began to realize she needs to start making some efforts if she wants to leave behind that situation and get well.

Finally, at the request of the mother, the mediator accompanies her to her first appointment with the psychiatrist and, from that moment, she decides to go by herself and initiate the treatment. As a result, the boy attends regularly to school. The educational centre and the Roma organization monitor the case for six months, and once the situation is normalized, the intervention is finalized.

CATALONIA, SPAIN

In Catalonia, the Ministry of Health of the Catalan government is responsible for the Health Mediation Plan.

The percentage of foreign-born in the population at large increased nearly six-fold, from 2.9% in 2000 to 15.7% in 2011, according to the Catalanian official statistical website.¹² This **dramatic demographic change** presented a challenge to public health services, which were obliged to adapt in order to meet the new demands and needs of the migrant population. To do so, the Catalan government

decided in 2005 to draw up a **Master Plan for Immigration and Health (MPIH)** (*Pla Director d'Immigració en l'àmbit de la Salut*), in order to define strategies for the improvement of migrant access to healthcare, as well as the quality of the services provided to them. The plan aimed to acquire better information about the health situation of migrant population in Catalonia in order to design strategies for adapting the health system to the newly arisen needs and demands. Three main areas of intervention were defined in the MPIH action plan for 2007-2010: *reception, mediation, and professional training plans*.

The Catalan Parliament is currently (2016) debating the approval of a new governmental agreement on a Universal Health Coverage System, whereby all citizens will be issued health cards upon registration at the town hall, regardless their legal status or length of residence in Catalonia. This will benefit all migrant population, including Roma foreign nationals.

The mediation plan: In the overall context of reception, equality, and accommodation policies, and in accordance with what was proposed by the Citizenship and Immigration Plan of the Catalan Government, it was necessary to introduce the role of the mediation professional in the field of health. The incorporation of mediators into the health system enabled the provision of better attention to health needs, as well as to improve the accessibility and autonomous use of health resources.

The role of intercultural mediator arose to facilitate intercultural relations, above all during the initial contact period. The knowledge mediators have of the language of origin, both cultures, and the language of the country of reception are the keys to enabling improved knowledge and communication between professionals and the migrant population. Mediation should be regarded as a provisional and temporary mechanism to get around great cultural-linguistic difficulties in the case of new arrivals during the time necessary for them to undergo a process of progressive integration.

In the past, some informal initiatives have been developed in the area of mediation. These have generally been directed voluntarily by sensitive and motivated professionals in response to the phenomenon of immigration, especially in those areas where the migrant population began arriving many years ago. The various mediation models have been and continue to be diverse. The overall aim, however, is consistent - to overcome the situations of inequality and exclusion in which various groups find themselves with respect to the health system.

¹² www.idescat.cat

The general objectives of the mediation plan were as follows:

- Define profiles and competences of mediators
- Define the situation of mediation in Catalonia and calculate the mediators' needs
- Raise the money to fund the activities
- Implement
- Evaluate

In Catalonia, there were defined **different profiles of a mediator**: translator, intercultural mediator, community health worker, and foreign health professional. In 2005, there were 99 people working as intercultural mediators in the health sector (41 full-time equivalents). Later, it was calculated that 50 new mediators were needed to cover all the mediation needs in the Catalan health sector.

A project was supported by a private financial institution, 'La Caixa Foundation' (Fundació Bancaria La Caixa-FBLC), which agreed to negotiate a public agreement to hire 50 new intercultural mediators and to train 101 mediators in all, during 2008 and 2009. Of these, 81% were women and 19% were men. They were providing services of mediation in 31 Hospitals and 94 Primary Health Care centres. The Ministry of Health signed a new agreement to fund 25 IM in 2010 and 15 in 2011, assuming the cost of this resource. Finally, in 2012 a new agreement signed by FLBC allowed to keep 9 of these mediators until 2016. The MoH has also been funding another 17 mediators in the Barcelona region since 2010. Roma mediators are funded through NGOs (90% public funds).

The Intercultural Mediation program was evaluated qualitatively in 2009 as part of the agreement with FBLC, and quantitatively (intercultural mediation interventions) from 2008 until now.

Tasks of IMs

- To inform to the patients about the rules and how the health system works and to cooperate with the healthcare professional to check that the information has been understood properly.
- To translate the language content, ensuring a correct translation and adapted to the situation.
- To avoid specific communication difficulties of each situation, taking into account the social and cultural context of the participants/speakers.
- To collect the request of the user or the professional, to identify the cultural elements that may influence in the qualitative development of the case.
- To identify situations that can cause or result in a shock or cultural conflict, informing the professionals in order to take the most appropriate actions to prevent or resolve a possible conflict, negotiating between the two parties in the resolution of the process.
- To follow up the cases in a multidisciplinary way.
- To record their activity in the IT system established.
- To support the PHC Centre community programs to improve knowledge and attitudes and to promote healthy behaviours.
- To develop, as part of a team, community projects related to the needs of each area and its population. These projects can be developed together with the health professionals from the PHC centre.
- To regularly analyse and evaluate their work.

At the initial stages of the Mediation Plan in Catalonia we identified the following selection criteria

- Primary education
- Nationality
- Spanish level
- Number of languages spoken
- Time of residence in Catalonia
- Basic knowledge of the Spanish cultural
- Interview (knowledge of community needs, contacts with NGOs, associations)

Principles in the Ethical Code

- Impartiality
- Neutrality
- Respect towards the individuals and their communities
- Professionally and Integrity
- Cultural sensibility
- Confidentiality

Initial Training

In 2008 and 2009, the Immigration and Health Plan of the MoH, together with the Institute of Health Studies (IES), organized a training course for 51 existing mediators and 50 new health mediators.

The course's objective was to offer a continuing training for all the health mediators, either the ones that already were working for the system or the new ones. The course for the 51 existing mediators included a 200 hours programme, with 120 hours of theory and 20 hours for their supervision.

The total learning time for the 25 new health mediators was 345 hours: 240 hours of theoretical sessions and 105 hours of supervised practice at the health centres where they have been assigned for their work.¹³ The course contained the following elements:

- Immigration and multiculturalism in Spain.
- Medical anthropology: immigration, culture and health.
- The Spanish Health System.
- Health in the Western world.
- Cultural competency.
- The intercultural patient-health professional/health mediator relation.
- Translation.
- Intercultural mediation and professional identity.
- Community health planning.
- Roles of Health Mediation and health aspects of cultural mediation.
- Patients' Rights and Duties. Ethics in Health Mediation.
- Intercultural Mediation with the main ethnic groups in Spain.

¹³ The course is available in Spanish at <http://bit.ly/xkL9XD>.

The 50 new mediators started to work at the centres after the first month of the employment contract. Mediators were assigned to different health centres according to the needs identified by the health regions. Each centre had to provide a mediator's professional tutor to supervise the practical training and make sure that the mediator had a computer, a company mobile phone, and a workspace. As well as evaluating mediators and the training process periodically, programme coordinators were in touch with these tutors in order to answer any question or solve any problems they may have.

Continuing education

Through the current mediation program, the intercultural mediators are offered monthly continuing education sessions on: community health, gender violence, epidemiological surveillance, mental health and drug additions, maternal and child health care; legal changes on health services entitlement, healthy habits, vaccinations, international health, etc.

They also have a monthly coaching session that concludes with a role-play followed by group supervision. The role-plays draw from theatre improvisation and therapy, with the students participating in "live" mediations. They use various experiential/ corporal activities. The group supervision draws from Interpersonal Process Recall (IPR) as psychotherapy supervision. It also includes a focus on the application of theory to practice, role confusion, management of complicated situations, and self-reflection.

Evaluation

In Catalonia, we have different evaluation models of the program:

- Academic training evaluation: an exam; an essay; a case analysis and a mediation audio recording to evaluate their strengths and weaknesses when mediating
- A qualitative study was carried out at the end of 2009 (Carratala Pèrez, 2009)
- Mediators' tutors are evaluating the IM performance periodically
- In 2016 we have done an qualitative session of self-evaluation of the IM services
- Quantitative evaluation: an IT system was developed in 2008 by the MoH to register the activity of the IM (system named RAMI). We analyse the data every three months and create a report.

One of the tasks of the intercultural mediators in Catalonia is to work at the community level together with the health professionals of the Primary Health Care Centers (Doctors, Nurses and Social Workers). One of the cases we had was a group of people from Pakistan affected by Tuberculosis that were not doing the treatment properly and were not attending the scheduled visits. The project lasted 9 months. Through research and surveys, mediators found that the main causes of this situation were: lack of knowledge and information about diseases and a lack of trust in the Catalan health system.

The main objectives to achieve were the compliance with treatment for tuberculosis of the Pakistani community in the area where the problem was detected, To get them to understand the severity of the disease. To make compatible the work time of the patients with the hospital working time. To get them to trust the Catalan health system.

To do so the intercultural mediators planned to organize information meetings, individually or by groups, for the community to raise awareness about tuberculosis: to organize workshops and lectures on health education; to produce materials adapted to the community needs, train patients and leaders to work with the community as equals, to coordinate with the Pakistani press in the area, to publish in the Pakistani press (paper and web) the working times of the health centers; to conduct monthly meetings with the associations of Pakistan people in the area to inform about the timetables of the health centers; to facilitate the access to the mediators interventions and to promote participation.

The results were: they achieved to carried out 90% of the programmed informative workshops; 80% of the Pakistan community leaders attended the workshops; the adapted material was used in the 90% of the visits; 80% of the Pakistan newspapers published the health centers working times; 70% of the Pakistan associations were informed of the health centers working times; they could done 90% of the scheduled visits.

Therefore the figure of the intercultural mediator built confidence, encouraged group cohesion and the participation of the Pakistani community, especially women. They also responded to the needs of the group and facilitated the implementation of the community interventions.

Information compiled and edited by	<p>Marta Escobar-Ballesta. CESPYD-Universidad de Sevilla, martaeb@us.es</p> <p>Javier Arza. Departamento de Trabajo Social. Universidad Pública de Navarra. Campus Arrosadia. 31006 Pamplona. Telf: 627464368. javier.arza@unavarra.es</p> <p>Tona Lizana-Alcazo, Head of Migration and International Health. Catalan Agency of Public Health. Health Ministry of the Catalan Government. C/ Roc Boronat, 81-95 - Edifici Salvany (tercera planta), 08005 Barcelona Telf. + 34 93 551 3633; tlizana_ext@gencat.cat</p>
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Contact information for Equi-Sastipen-Roma's health mediation program	<p>José Antonio Jiménez y Marlen Menéndez. Asociación UNGA. C/ Cabo Peñas, 4 Bajo, 33011 Oviedo. Telf: 985 111 404. aupre@hotmail.com</p> <p>Javier Arza. Departamento de Trabajo Social. Universidad Pública de Navarra. Campus Arrosadia. 31006 Pamplona. Telf: 627464368. javier.arza@unavarra.es</p>
Acknowledgements	<p>Manuel García-Ramírez. CESPYD-Universidad de Sevilla. magarcia@us.es</p> <p>José Antonio Jiménez y Marlen Menéndez. Asociación UNGA. C/ Cabo Peñas, 4 Bajo, 33011 Oviedo. Telf: 985 111 404. aupre@hotmail.com</p>

FRANCE

In France, there is no legal notion of “ethnic groups”. The number of people from Eastern Europe living in slums in France is estimated between at between 15,000 and 20,000. Most of them are Roma who came from Romania and Bulgaria after 2000, and who live in extremely precarious conditions.

The majority are considered by the authorities to be in an irregular situation. Until 2014, the transitional measures introduced by the French government since the entry of Romania and Bulgaria into the European Union, rendered legal employment for these Europeans living in France virtually impossible. However, greater opportunities for integration are now open to Romanian and Bulgarian nationals. People with good employability are no longer constrained by a system of prior control of the salaried activity, and can therefore work freely. As expected, however, for a large part of the poor migrants living in slums, the problem cannot only be summed up as a question of professional integration.

In addition to the individual and social determinants, the number of evictions is a hindering factor to integration. Time allocated for overall support services is often necessary to remove the obstacles to integration: finding housing, looking after oneself, circumventing or solving problems of illiteracy, and so on.

Unfortunately, the number of expulsion is high. “In 2015, more than 11 000 people were evicted from 111 slums or squat settlements. The effects are catastrophic especially in terms of social and medical support, and school drop-outs.”¹⁴ These policies have no other result other than to displace migrants temporarily without any impact on the nature of slums and squats.

In addition, these repeated evictions lead to a search for invisibility in order to slow down the pace of ejections. Two phenomena can be observed: on the one hand, isolated settlements (generally in unhealthy areas with lack of sanitary facilities and water points in the vicinity, dangerous connection to electricity, etc.) and far from transport and public services in general. On the other hand, a growing number of squats, less visible than open fields. This increases the precariousness of the already vulnerable populations residing there, and complicates the associative work by making it more difficult to locate and respond to people's needs.

As in the case of other populations living in precarious conditions and facing various barriers to healthcare access, organizations in the field find that the overall health situation of Roma migrant populations is extremely worrying. In order to overcome these difficulties, and particularly to improve the reception and follow-up of these populations in the public health structures, **health mediation was seen as the most relevant approach to be developed**. The health mediation program was designed with the objective of removing the main barriers to healthcare access for populations in precarious situations, with a non-existent or limited use of public services in France:

- Difficulties in access to domiciliation and health insurance
- Lack of information on the health system
- Communication barriers (foreign language, illiteracy, etc.)

¹⁴ Political Report National Human Rights, Collective Romeurope, 2015

- Interruption of care
- The lack of information of health professionals on the living conditions of the patients
- Lack of health education

The program initially focused on maternal and child health (women and young children aged 0-6 years) as health indicators for this segment of the population are particularly alarming: non-existent pregnancy monitoring, very low use of contraception, frequent recourse to abortion, very low immunization coverage and medical follow-up of children. **Now, the program has been extended and targets all Roma community members living in slums, although it continues to focus mainly on women and children.**

Dire living conditions, as those found in squats and slums, discriminatory practices, and diminished entitlements to health care for foreigners have a direct impact on overall determinants of health.

Access to health services and entitlements

Health services are difficult to access for slum and squats dwellers because they are not reached by health actions “outside the walls,” and also because their places of residence are generally located far from health facilities.

Access to professional interpreting is an essential element for people to access quality care. However, health services rarely make use of these services in the case of slum dwellers: in 2015, only 20 of the 205 health facilities which were partnered with the mediation program actually used it. The lack of understanding of the discourse on this topic on the part of health professional leads to professional dissatisfaction of the professional himself, disengagement of the patient in relation to his or her own health, and possible errors in medical treatments and follow-ups.

Most slum dwellers are eligible for the AME (Aide Médicale de l’Etat - Medical aid from the State) or for the CMU (Couverture Maladie Universelle – universal health coverage). **The main issue in accessing health insurance is obtaining an address registration for administrative purposes.** However, few municipalities comply with the law requiring them to domicile the people living on their territory. This has the direct consequence of limiting the access to health services for people who are living in remote areas and who are not sufficiently mobile to go to an institution in person, sometimes located more than an hour away from their residence.

On the other hand, while approximately 60% of the people supported by the mediators of the program were covered by health insurance in 2015, the associations noted difficulties in ensuring healthcare access for the rest: duration of processing by the CPAM (Caisses Primaires d'Assurance Maladie – primary health insurance funds) goes beyond the timeframe provided by law and is impeded by administrative barriers or requests for additional documents.

Access to primary health and general practitioners is also an important element: In France, the general practitioner (GP) ensures primary access to healthcare, as well as and medical treatment coordination; the service is accessible to the beneficiaries of the AME. However, this remains very partial and still under-developed in certain territories. Refusal of care has also been documented by health mediators: 13 such cases were reported in 2015.

Environmental and housing conditions

Local authorities have little regard for their obligations, which mandate them to guarantee access to water, electricity, and garbage collection to people living in slums on their territory. According to the 2015 evaluation report of the National Health Mediation Program, more than half of the places where the mediators intervened were affected by high levels of insalubrity:

- Absence of rubbish bins and garbage collection (96%);
- Places of life with a presence of "enormously" or "a lot" of refuse (70%);
- Presence of pests in 81% of the sites to the knowledge of mediators;
- More than half of the sites do not have access to toilets (60%).

Overcrowded housing, living conditions, and migratory pathways are factors that **increase the risk of transmission of epidemic-prone diseases** such as tuberculosis.

The age of the squats and soil pollution in and around the settlements pose risks of exposure to lead. The presence of old peeling paint and ironwork suggest that some residents may be affected by lead poisoning.

Instability of dwellings

This is an anxiety and demobilization factor. When people are expelled from their place of residence and find themselves in another commune or region, they can lose the links they had difficulty in establishing with the local health network, which can lead to interruption of care. People must then re-establish rapport with new health structures that do not necessarily have the same reception conditions. There is no precise study on this issue, but experts in the field have found that recurrent expulsions negatively impact overall health, and in addition cause anxiety and interruption of treatment, all of which can have serious consequences for individual and public health.

The mediator profession in France is still under development

- Work has been underway for many years to structure the profession of **social mediator**: a unique definition, a reference framework, an ethical framework, diploma courses and a professional code. This profession is now officially recognised, via the article 67 of the Equality Citizenship Act, which proposes to include social mediation in the code of social action and families. A professional standard in social mediation has just been published and aims to support its technical recognition.
- On the other hand, health mediation has been recognized institutionally within the framework of the Modernization of our Health System Act, which provides for the development of "benchmarks of competence, training and good practice" concerning health mediation and linguistic interpreting. Mandated by the Ministry of Social Affairs and Health, the High Authority of Health has started consultations with stakeholders since October 2016. These benchmarks should be finalized in the spring of 2017 following a period of public consultation.

Mediation in health within the framework of the National Program of Health Mediation¹⁵

Within the national program of health mediation for vulnerable groups, mediators are employed by local associations which have already worked with this public or in the medical field. The role of the mediator is to **create connections** between the target population and healthcare actors in order to build up access to the public health system for vulnerable groups.

The mediators are professionals with **at least a two years postgraduate degree in social, medicine, or anthropology**. They are not necessarily from the community, but they speak the language and have a good knowledge of the target public. The mediators have to be independent of the two parties, and be able to dialogue with both of them. The mediators receive additional training within the framework of the program, and they often meet to exchange good practices and other valuable insights.

They are included in a multidisciplinary team inside the association and work in partnership with others local organisations. In this way, they can meet demands which transcend the field of health.

History

All stakeholders on the ground have deplored the very poor health of Roma migrant population, which is due to poor living conditions and difficult healthcare access in both their native countries and in France.

In 2008-2009, based on this observation, the national collective Romeurope defined a program of health mediation, with the **support of the Ministry of Health and the National Institute of Health Prevention and education**. The project aimed to develop mediation actions in order to improve access to health care and prevention to public health services for Roma and other vulnerable groups living in France.

The program was coordinated by **ASAV, l'Association pour l'Accueil des Voyageurs**,¹⁶ a non-profit organisation which has worked with Travellers and Roma for 20 years. It promotes access of health and social rights for these at-risk populations. They coordinate projects, monitor and evaluate actions, train mediators, and network with local associations in the development of health mediation actions.

With the support of the Ministry of Health, the scope of the health mediation program (geography and target population) was extended over the period 2013-2016 by developing actions in other territories and by targeting the entire Roma population (the initial focus was on maternal and child health). The challenge of this broadening scope was in the adaptation of the program to other groups experiencing similar barriers to access healthcare, such as Travelers in precarious situations. Health mediation aimed at this public was included in the multiannual plan against poverty and social inclusion formally adopted by the French government on 21 January 2013.

¹⁵ referential of the National Program of Sanitary Mediation: www.mediation-sanitaire.org/wp-content/uploads/2016/04/R%C3%A9f%C3%A9rentiel-programme.pdf

¹⁶ www.fnasat.asso.fr/assoce/92asav.html

In 2016, the program included fourteen mediators from twelve local associations, working in the cities of Caen, Grenoble, Lille, Lyon, Marseilles, Nantes, Rouen, Montpellier, and in Ile-de-France.

Responsible Institutions

A committee composed of representatives of national institutions, national and local donors and partner associations was set up to monitor and steer the program. These actors are convened once a year. The committee consists of:

- the Directorate-General for Health (DGS)
- the Public Health Agency France (formerly INPES)
- the Directorate General of Social Cohesion (DGCS)
- the Directorate of Social Security (DSS)
- the Regional Directorate for Youth, Sports and Social Cohesion, Ile-de-France (DRJSCS)
- the General Secretariat of the Interministerial Committee of Cities (SG CIV)
- the Regional health agencies of the regions concerned
- the Regional councils involved in local projects
- the CNDH Romeurope
- FNASAT Gdv
- the Associations carrying out the project at national and local level: AREA, Aréas dispositif de La Sauvegarde du Nord, AŠAV, Les Forges, Médecins du Monde, Première Urgence Internationale, Relais Accueil Gens du Voyage, Roms Action, SoliHA.

The National Health Mediation Program receives financial support from the Ministry of Health and the French Public Health Agency.

Job Description

Within the framework of this national health mediation program, each of the mediators provides missions in support, articulation, and complementarity of the teams of each structure, in favour of global approach:

For people residing in slums/squats

- Information on health care structures and the health system (collective activities and dissemination of translated / imaged tools).
- Orientation to care structures and health professionals.
- Information and referral to local relays responsible for entitlements: health insurance, permit to stay, family benefits.
- Participation in prevention and health education activities led by partners.
- Physical accompaniment at important medical appointments.

For local institutional partners

- Raising awareness and informing health actors and institutions about the specifics of Roma migrant populations to better address their need in public health services.
- Promotion of health education activities directly at places of life.
- Animation/participation in the partnership health network around the health of slum dwellers (health structures, associations, doctors, health institutions, elected officials and local authorities).

Within the local structure and the national network

- Identification and consolidation of territorial health networks under common law.
- Participation in observation missions on the rights of precarious Europeans and slum dwellers.
- Reporting of information gathered in the field to the host organization and coordination of the national health mediation program.
- Participation in team meetings within the host organization.
- Provide periodic information on indicators of access to care and prevention of people being followed.
- Participation in various mediation and health networks, local and national, with a view to exchanging practices.
- Participation in the national dimension of the health mediation program: training, exchanges of practices, evaluations, working group on the development of prevention tools.

Ethical Code

Health mediation shares the ethical principles set out in the charter of reference for social mediation. This was **established and adopted in 2001 by the Inter-Ministerial Committee of Cities**.

The charter of reference for social mediation

Social mediators must comply with a number of legal and ethical rules that define what is permitted and what is prohibited by law. These rules, which in a way constitute the rights and duties of social mediators, are the guarantees of protection for the users, the public, the mediators, and the partners. They also guarantee the effectiveness and the sustainability of the intervention process as a whole.

1. General principles

Neutrality and impartiality

Neutrality and impartiality are the general principles guiding the intervention of social mediators, which should not favour one party or the other. The application of these principles depends on the recognition of the status of the mediator and presupposes appropriate training. The intervention by two mediators at the same time can contribute to a better compliance with these principles.

Negotiation and dialogue

Mediation takes place within the framework of negotiation and dialogue: it is never imposed by an authority, even if it is applied in reference to legislations, or rules of collective life.

Free consent and participation of the inhabitants

Social mediation is based on the free consent of the parties. At any time, it is possible for either party to withdraw this consent. Mediation must be based on the constant search for the parties' adherence to the objectives of their interventions. It must aim at obtaining the participation of the inhabitants in the resolution of the dispute which opposes them or in improving the communication and the social link between them. This objective imposes on the mediator a duty to explain the conditions of his intervention and its limits.

The mobilization of institutions

By promoting citizenship and revealing institutional dysfunctions, social mediation contributes to the modernization of institutions, their closer proximity with the inhabitants and users of public services and their adaptation to new needs. Social mediation thus contributes to the proper exercise of public services without acting as a substitute and without creating a gap between the institutions and the public.

Protection of human rights

Social mediation tends to protect people and their rights. It cannot substitute for services or rights guaranteed to everyone. It leads to an improvement in social relations without ever obliging anyone to renounce their rights.

Respect for fundamental rights

Social mediation must offer all the guarantees set out in the European Convention on Human Rights and relevant case-law, both in the mechanisms it implements and in the solutions it promotes. Mediation must be conducted with respect for public freedoms and regulations that protect privacy.

2. Mediator attitudes

The mediator's discretion and obligations under the law

Discretion and respect for anonymity are imposed on the mediator, whose recognition rests on the confidence he inspires in the parties. The mediator may only use the information gathered during the mediation (whether in confidence or observation) with the agreement of the parties, in compliance with existing laws.

In carrying out their activities, social mediators face complex situations that do not relieve them of their responsibilities as citizens under the law (obligation to provide assistance to a person at risk, an obligation to report crimes and violence against particularly vulnerable people, etc.)

Considering these elements, it is the responsibility of the employer to remind the mediator the kind of information that can be shared and the conditions under which this may occur, which must be done in a way that ensures their protection.

Disinterestedness and freedom of the mediator

Mediation is fundamentally disinterested: the mediator, apart from the remuneration he can receive from his employer, must not use his influence or his position to obtain any benefit from the inhabitants, the users or the structures within which he/she intervenes.

Depending on the situation, the specific nature of the conflict or the problem, the place or the persons involved, the mediator can refuse an intervention.

In special circumstances, it may also be required to discontinue an action. However, the mediator should not make this decision alone and, if the conditions are met, he will have to pass the relay.

Profile of the Mediator

Know-how

- Minimum training: high school diploma + 2years (social, health, ethnology).

- Proficiency in French and Romanian (or languages of the field of intervention: Bulgarian, Serbian ...).
- Knowledge of the healthcare system and social protection in France.
- Experience working with associations and/or local institutional partners.
- Experience in mediation, health education or health promotion.
- Driver's license (if places of intervention are difficult to access by public transport).

Personal skills

- Ability to listen and empathize, diplomacy.
- Editorial capacity.
- Intercultural sensitivity.
- Ability to adapt and work independently.
- Team spirit.

Initial Training

The basic training (five days) of health mediators aims to enable them to:

- Understand the organization of the health system, the provision of care and the network for health promotion. The health mediator must identify the entitlements users could benefit from. He/she should also be able to identify the institutional and associative networks to be mobilized at the local level according to the situation at hand.
- Be able to inform, guide people and communicate with caregivers based on basic public health knowledge (maternal and child health, prevention, health education, stakes of precariousness, environmental health: place residence, professional activities, drug abuse, etc.)
- Understand keys sociological and ethnological concepts related to the target audience in order to decipher situations. This knowledge allows the mediator to consider the person as a whole and to put into perspective different factors impacting the health of the person.
- Rely on a solid dispute resolution position, consistent with the principle of social mediation.
- Have good communication skills in order to conduct mediation and to manage crisis situations, but also to establish relationships with institutions, to write letters, identify resource persons, advocate, and formulate intentions.

Continuing education

Further training is offered to mediators throughout the year. Topics correspond to the needs identified and the requests of the mediators. Over the past four years, the following themes have been taught:

- Health education in health mediation,
- Prevention of lead poisoning,
- Prevention of violence against women,
- Prevention of addictions,
- First aid,
- Community approach to Health.

In addition, the national coordination of the program organizes **national mediator meetings** five times a year. These include:

Time for exchange of practices: facilitated by the coordination of the PNMS (Program National de Mediation Sanitaire - National Health Mediation Program), they allow mediators to analyse and exchange their practices with peers working in similar. Bringing together the mediators of the program who work in different territories, these meetings help to federate around a common framework of reference, to “decompartmentalize” their practices and to conduct a collective reflection on their positioning and solutions to problematic situations. Regular meetings help to break the feeling of isolation sometimes felt by mediators. This is explained by a strong demand from the public they serve, for whom the mediator is usually a privileged interlocutor - if not the only one - but also because of the difficulty of acting as an intermediary between health professionals and a very isolated and disenfranchised segment of the population.

Time for analysis of the practice: coordinated by a psychologist. The analysis always starts from the real situations encountered in practice. The case-study approach allows to highlight different dimensions of the work, as well as its emotional resonances. This section aims more specifically to:

- analyse together, between peers practicing the same professional activity, the conditions and working methods;
- compare situations and practices to identify commonalities and differences;
- encourage expertise exchange and integration of newly recruited mediators;
- explore alternative practices likely to overcome obstacles encountered;
- collectively shape the development of the profession, i.e. rules, principles, guidelines for professional practice
- reduce the sense of isolation and loneliness in fieldwork

Working time on prevention tools: In order to develop the autonomy of accompanied persons, tools are developed by health actors in collaboration with mediators to enable the target public to learn more about the French healthcare system and to improve its own access to it.

Mediators also participate in the creation of health prevention tools on different topics: tuberculosis and pregnancy monitoring, sexual and reproductive health.

A working group meets twice a year with the mediators of the program in order to share health education materials, create and adapt prevention and support materials to an allophone and/or illiterate public, or to a different territory. Mediators also participate in the testing of tools developed by Santé Publique France – Public Health France to improve their functionality and accessibility.

Selection

The recruitment of health mediators is carried out entirely by the employer organization, which remains responsible for the project. The organisation that coordinate the program can be contacted to provide templates for terms or references or feedbacks on candidates.

Reporting and Evaluation

From 2013 to 2016, by integrating the National Health Mediation Program, health mediation projects were evaluated jointly by external providers.

Over these four years, the objectives of the evaluation process were to:

- Map local mediation actions;
- Adjust mediation practices based on field results;
- Assess the effects of national coordination;
- Foster advocacy for recognition of actions and, more broadly, of health mediation;

The tools:

Concerning mediation actions for the Roma population living in slums, the indicators forms developed by the coordination in association with the associations were used to support the collection of data in the field:

- description of dwellings(one per place of intervention)
- general index of healthcare access indicators and of prevention mechanisms (one per local mediation project)

Collection:

The mediator(s) of each structure compiled collected information once a year (2013, 2014, and 2015) and forwarded it to the program coordinators, who are responsible for centralizing this data; The data was then transmitted to the service provider responsible for the operational implementation of the evaluation (Novascopia) for aggregation and analysis.¹⁷

EMPOWERMENT & MAINTENANCE IN A NETWORK OF PROXIMITY HEALTH ACTORS

"Mrs. E. is living in France for 5 years and has lived with her family for a long time in a squat in Ablon (Val-de-Marne, 94), where several expulsions forced them to find another place to live in Verriers les Bushes first (in the 91) and then in a shantytown in Rungis (94). She was accompanied by our team two years ago in Ablon. In spite of the evictions she was able to continue to benefit from a domiciliation and the three municipalities where she resided are relatively close to the scale of the Île de France. E. now knows very well the health structures (hospitals, PMI – Maternal and children protection, CMS - Municipal Health Centers), she has taken steps to renew her MEA, as well as the PMI follow-up for her children, continued her gynecological follow-up in a private practice and when her young daughter-in-law needed contraception, she was able to accompany her and introduce her to the specialist without the need for an intermediary.

SUPPORTING RELAY ACTIONS BETWEEN INHABITANTS

In a shantytown in the Greater Grenoble area, a 23-year-old woman facilitated the referral of a loved one to the family planning center (CPEF) and to the dentist. She found the dentist with the support of the mediator and the CPEF due to previous visit for an emergency consultation. Speaking French with a sufficient level to understand and specify her request, she accompanied this person to make appointments and even in the consultation due to the lack of professional interpreter.

FACILITATING ACCESS TO GENERAL MEDICINE

¹⁷ Interim and final evaluation reports are available on the program website: www.mediation-sanitaire.org/le-programme/evaluation/

Mr. C. has a chronic condition and was admitted to the PASS (Permanence for access to health care). When he got access to the CMU, he decides to go to a physician on his own "It's great, I do not need to move far and wait for hours at the PASS without knowing if I would have a consultation. My doctor is very nice, he knows all my health problems. I can even go there without an appointment on Thursday, but I sometimes have a hard time understanding everything he tells me, so it's still practical that you (the mediator) come to see me from time to time to help me find myself in my prescription for drugs "

www.mediation-sanitaire.org

Lucile Gacon (Coordinator of the National Health Mediation Program)

lucile.gacon@asav92.fr