THE HEALTH MEDIATORS AND THE NEED FOR AN INTERCULTURAL APPROACH TO HEALTH WITHIN ROMA COMMUNITIES

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Abstract:
Romania has a network of health mediators, meant to facilitate the communication between Roma communities and the medical staff. In this qualitative study, using data collected from three focus-groups with health mediators from Iaşi and Cluj counties, we provide significant information about the problematic issues related to the Roma population. The main challenges are the barriers affecting access to healthcare and the peculiarities of this ethnic group. Access to and healthcare provision would be improved with the development of the health professionals` cultural competences. Health mediators are the key elements in this process, all the more so as they are able to render innovative, collaborative care and program building with family physicians and hospitals, committed to the comprehensive and preventive treatment of the Roma population.

Key words:
Cultural competence, health mediator, Roma community, healthcare.

Introduction

The quality of the healthcare provided to the ethnic minority populations is not at the same level as that provided to majority group patients[68]. Discrimination experiences exist even within the health system.

The Roma [Gypsies, Romani] constitute the largest ethnic minority in the South-East of Europe. Their situation has been analysed in many

[68] J.G. Ponterotto, J.M. Casas, L.A. Suzuki & C.M. Alexander (eds.), 1995; C. Seeleman, J. Suurmond, K. Stronks, 2009, pp. 229-237.

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documents of the European Union, focused on protecting minorities and providing them with opportunities to improve the current situation. Recent research have repeatedly identified a major decline of the socioeconomic status of the Roma in south-eastern Europe, marked by social exclusion, poverty, poor living conditions, unemployment, low education levels, discrimination and racism, that lead to major disparities between the status of the Roma and the majority[69].

The restricted access to healthcare services and the precariousness of the health status amongst the Romanian Roma, by comparison to the majority population, has been documented by numerous sociological studies[70]. These studies have found that, despite the high degree to which the Roma population has been included in the public healthcare system and the growth in number of the national health programmes over the past ten years, important factors of latent discrimination linger in the Romanian healthcare system.

Zhang and Verhoef[71] have proven that a main determinant of the health status among minorities is the relationship they have with the medical staff. Cultural differences between care providers and patients belonging to other ethnic groups may create barriers to effective communication and treatment, through the misinterpretation of patients' symptoms and the difficulty in transmitting medical knowledge to members of traditional ethnic communities. The concept of *cultural competence* has been extensively debated upon as a strategy for improving the quality of healthcare and eliminating ethnic disparities in the health system[72]. Culture refers to the integrated patterns of human behaviour that include language, thoughts, communication, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. In turn, cultural competence has been broadly defined as „a set of congruent behaviours, attitudes, and

[69] Á. Molnár, R. Ádány, B. Ádám, G. Gulis, K. Kása, 2010, pp. 1240-1247; D. Ringold, M.A. Orenstein, E. Wilkens, 2005; A. Revenga, D. Ringold, W.M. Tracy, 2002; S. Hajioff & M. McKee, 2000, pp. 864-869.
[70] V. Astărăstoae, C. Gavrilovici, M.C. Vicol, D. Gergely, S. Ion, 2011; S. Cace & C. Vlădescu, 2004.
[71] J. Zhang & M.J. Verhoef, 2002, pp. 1795-1802.
[72] M. Leininger, 2002, pp. 189-192.

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policies that come together in a system, agency or among professionals that enable effective work in cross-cultural situations"[73].

An efficient model that directly addresses the linguistic and cultural problems of such groups accessing healthcare services is based on using a *team of cultural support*, which works with both medical staff and community members. The members of such a team, called *intercultural mediators*, often originating from the ethnic community, are appointed as community health workers. They facilitate the border crossing of another person or group of people from one culture to another culture. Following the practice of other countries, Romania has also created a network of health mediators (HM), persons recruited from among Roma women. The aim of their activity is to facilitate the Roma's access to the healthcare system and to encourage a non-discriminatory attitude and equal treatment from healthcare providers when working with Roma patients, and, ultimately, to facilitate communication between community and medical staff[74].

HM have been trained by an NGO, Romani CRISS. The Romanian Government Order no. 619/14.08.2002 regulates the activity of HMs and includes the technical framework for the organization, functioning and financing of their activity. The HM's job is considered as an interface between the community and local partners (family physicians, local authorities, etc.)

The objectives of this study are to determine the role of HMs as intercultural factors contributing to healthcare quality among Romanian Roma patients and to point out their cultural competence in the community where they work.

2. Methodology

We have chosen the focus group technique, because it is an interactive one that creates the opportunities for an easier communication and free discussions. At the same time, it offers a more relaxed atmosphere for discussing more sensitive subjects[75].

Participants and recruitment

We have organised three focus groups (fg) with 30 HMs from the counties of Iaşi and Cluj (Romania), the research being conducted between

[73] T. Cross, B.Bazron, K. Dennis, & M. Isaacs, 1989.
[74] *** *European Network Sastipen. Annual Report 2005-2006*, 2007.
[75] C. J. Kitzinger, 1995, pp. 299-302.

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January and March 2012. We gathered the contact information of some HMs from the Department of Public Health. In Iaşi, the participants were contacted on the phone with the support of the counsellor of the prefect of Iaşi, who provided the research team with the contact details of the HMs. They made efforts to come to the Prefectures in both cities, where the focus groups were conducted. Others expressed their regret for not being able to respond positively to the request. The communities served by the participants in focus groups were either traditional or Roma communities with „Romanianized" members (as the respondents defined themselves) or mixed communities. The traditional communities investigated were spoon makers, musicians, bears tamers, wood crafters, coppersmiths and tinsmiths who preserve ethnic traditions regarding the perception of illness and patient care.

Group interview guide

During our research we have used a semi-structured guide for the focus group, aiming at facilitating discussion about the determinants of the quality of life of a chronic patient in the Roma community. The guide covered aspects concerning illness and the attitude towards the patients (in community and family), the attitude of Roma towards the health system and health in general (preventive attitudes, health insurance, etc.), respect for the patient during all medical interventions, misbehaviour or mistakes in the attitude of Roma who seek health care, customs and traditions related to death and funerals in the Roma community, etc.

Procedure

At the beginning of the focus groups, the participants signed agreements for personal data processing and provided, in a table, demographic data: name, age, education level, the Roma group they belong to. With their permission, discussions were audio recorded and then transcribed. Confidentiality was guaranteed and they were assured that in the studies based on the data gathered during the focus groups their identity would not be disclosed. Each focus group lasted for 60 to 80 minutes.

Analysis strategy

The analysis of the discussions was conducted using the interpretative phenomenology analysis[76], a method that allows the researcher to identify topics and generate a coherent interpretation of these topics.

[76] J. A. Smith, 1996, pp. 261-271.

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The transcripts were analysed according to the frequency of the topics. Related topics were grouped. The interpretation of the topics is illustrated by excerpts from the transcripts.

Qualitative analysis revealed the experience of Roma seeking medical services. The health mediators told us about their experience related to the direct contact with Roma ethnics and their living environment, living conditions and the problems they encounter. The responses integrated personal experiences, information about the social context, aspects of the local history, etc. The three focus groups facilitated a better understanding of how health mediators work and the difficulties they encounter.

3. Results

Access to and providing healthcare are problematic issues related to the Roma population. The main challenges are the barriers affecting access to healthcare and the peculiarities of these ethnic groups.

Barriers Hindering Access to Healthcare for Roma Patients: A Two-Faceted Coin

Lack of financial resources and health insurance coverage

The Roma are often faced with *economic problems* and poverty[77]. The patients and their families fully experience financial difficulties[78]:

There are persons suffering of cancer and they believe that treating cancer requires large sums of money so that they prefer not to go to the doctor anymore. (fg. 3)

The availability and appropriate use of healthcare services by the Roma are often hampered by the lack of financial resources.

In the Romanian healthcare system, patients are registered to one family physician of their choice, which provides the necessary basic care and is the gatekeeper to the next echelons of medical care. One of the conditions to be registered is to have health insurance coverage. Because of unemployment and the low educational level, sometimes because of the refusal to work[79], numerous Roma ethnics cannot afford paying for a health insurance, thus not having access to medical services. Although during focus groups respondents pointed to the lack of jobs for Roma, some HMs stated that:

[77] A. Revenga, D. Ringold, W. M. Tracy, 2002.
[78] E. J. Emanuel, D. L. Fairclough, J. Slutsman, L. L. Emanuel, 2000, pp. 451-459.
[79] G. Duminică & M. Preda, 2003.

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Some guys don't want to work. There have been courses: plumbers, carpenters, welders. We've registered them. They came for a few hours on the first and second day. I told them: "Dude, at the end of the course you'll get a certificate and ten million lei." Transport was covered. They came at the beginnin' and at the end. They wanted only the certificate and the money. There was no way to make them learn, no! They're used to being given and receiving. (fg. 2)

Under such conditions, one of the participants raises a question: "What is to be done by the HM? Can s/he pay the beneficiaries salaries or the insurance?" (fg. 1)

In other situations, the wealthy Roma voluntarily evade the payment of health insurance. As 55% of the Romanian citizens do not pay a health insurance[80], these answers suggest that even the Roma with a high economic level evade the payment of health insurance. Although they express their intention to benefit from the available medical services, evading the payment of health insurance is common practice, both among the Roma facing financial difficulties and among those with financial means.

Lack of cognitive resources

The lack of *cognitive resources* represented by limited education and language barriers hamper the provision of care to patients from different cultures in several aspects[81]. Some Roma patients in Romanian society are relatively poorly educated and have poor language proficiency[82]. When accessing medical services, the Roma may have difficulty in communicating symptoms or tend to misunderstand instructions given by the medical team.

The linguistic barriers between doctor and patient that affect the healthcare process[83] have been highlighted by the HMs:

Some of our folk can't talk properly when going to the doctor. If they keep talking Romani, people don't get what they're sayin'. (fg. 1)

Besides the linguistic factor, there are other differences between the Roma and the Romanian culture when it comes to describing and understanding medical symptoms. The interventions of the HMs in the discussions have highlighted this aspect:

[80] M. Lucan, 2012.
[81] J.A.M. Harmsen, R.M.D. Bernsen, M.A. Bruijnzeels, & L. Meeuwesen, 2008, pp. 155-162.
[82] C. Masseria, P. Mladovsky, & C. Hernández-Quevedo, 2010, pp. 549-554; P. Mladovsky, 2007.
[83] W.J. Ferguson & L.M. Candib, 2002; pp. 353-361; G. Flores, 2005, pp. 255-299.

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HM: They don't talk directly. We, when present there, talk differently with the doctor.

HM: Most didn't go to school. The doctor explains something, they understand somethin' else.

Interviewer: Do you have to go with them?

HM: I sometimes go, but as I am alone in P., there is a lot of struggle with them. (fg. 2)

Poor communication due to language barriers has a negative impact on many aspects of patient care, including patient comprehension and satisfaction[84]. Conversely, clear communication between patient and physician is an essential part of their relationship, leading to a better health status, greater, functional patient satisfaction, and an increased quality of care, which increases health care-seeking behaviour[85].

A first step toward facilitating communication between physicians and Roma patients and thus toward improving care for these patients is the provision of a HM as an interpreter:

The leech advises them, provides them with everything they need, but tells me to communicate. (fg. 1)

The HMs adjusts their way of communication according to the cultural norms of the patient. This is the best option because the HMs, as professional interpreters[86], have knowledge about medical terminology and may facilitate the exchange of information between the patient and the clinicians. The HMs can act both as translators and as cultural facilitators to get the best results in communicating with patients. They are able to pre-emptively inform the physician about the patient's cultural background.

As another study has proved before[87], involving the HM as professional interpreter in the process of communication between patient and physician has beneficial effects on the utilization of healthcare services, on clinical outcomes and the patients' satisfaction with the medical care received. Without the help of an HM, patients with limited Romanian proficiency and misunderstanding of medical terminology would receive lower-quality health care, and would have a greater chance of experiencing

[84] Y. Schenker, F. Wang, S.J. Selig, R. Ng, & A. Fernandez, 2007, pp. 294-299.
[85] C. Brach, I. Fraser, 2000, pp. 181-217.
[86] Y. Schenker et ali, 2007, pp. 294-299.
[87] R. Patridge & L. Proano, 2010, pp. 77-78.

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negative health outcomes. Given the clear benefits of their activity, the HMs should be included in the medical teams within the Roma communities.

Lack of personal hygiene

One of the defects of a part of the Roma population who seek medical services is the lack of personal hygiene:

There are people who go to the doctor without washing properly, so they smell. They're dirty... Added to that, personal hygiene is poor. (fg. 1)

In the relationship with doctors, the patient is the one to blame, as it was unanimously acknowledged, when "they don't display the proper behaviour, as the doctor expects, and which is proper" (fg. 1).

We know they are poor, others are on the threshold of poverty, but for us, in the village, we don't have running water. Roma women should wash. You can't go to the doctor, you can't go there lacking personal hygiene. (fg. 2)

HMs agree that the Roma's mentality should change, because at the moment they call the doctor "they should be clean, have hygiene, to show respect to the doctor" (fg. 1).

The participants in our research made us understand their efforts in fighting some customs and traditions deeply rooted in the behaviour of the communities. HMs work hard to convince people to change their behaviour, working carefully so that they do not offend or quarrel with the members of the Roma community:

It's difficult to tell a woman: Go and have a shower! One has to use diplomacy... Romani Criss taught me like this: You attend meetings with the women. I call 2, 3 women. The others are reluctant. Next week I'm calling Mrs. Violeta. They do the housework until I come. It's not easy as they are dirty, that's it. (fg. 1)

The discussions with the HMs indicate that the efficiency of health policies is strongly influenced by the involvement of the Roma[88]. During the focus groups, the HMs suggested that most of the Roma are not involved in implementing initiatives that directly concern them. A challenge for the HM is the way they could determine Roma men and women to be directly preoccupied with solving issues related to their health, a situation they could benefit from. Active involvement could improve the quality of life, according to their needs.

Patients' cultural values and preferences

[88] G. Fésüs, 2012; G. Fésüs, P. Östlin, M. McKee, R. Ádány, 2012, pp. 25-32; Council of the European Union, 2011.

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Understanding cultural values is crucial in providing adequate medical care to populations of diverse cultural and ethnic backgrounds. In order to understand the cultural norms and values of their patients, healthcare professionals should make a careful assessment of the patients' cultural features.

Cultural variations in health care beliefs were illustrated with examples from multiple Roma groups. These issues are crucial to preventive counselling, diagnosis, treatment, and the management of illness because culture shapes health-related beliefs, values, and hence, behaviours[89].

The shame of being ill

The perception and acceptance or rejection of certain diseases in the Roma community impact on how an individual suffering from a certain disease is seen by the others and may affect his/her willingness to seek medical help or support from family or the community. Cultural factors can lead to the stigmatization and marginalization of people who suffer from a disease that is considered to bring shame. For this reason, patients from Roma culture may avoid contacting a doctor, fearing that they will be judged for suffering from a certain disease.

They're ashamed. For example, in our village, if one suffers of cancer, people say it's contagious. And the others laugh at him. That's why they keep it secret. As an HM I approach them differently, I communicate more. And when I call the doctor I tell him the problem we have. (fg. 1)

In close communities, the differences between people on health status criteria are profound. The community rejects those having physical disabilities, infectious diseases or cancer, because people, inexplicably, fear transmissibility. Discrediting the patient as a member of the community alters his self-esteem[90].

Each case has its particularities. Some are ashamed, some fear that the neighbours find out or their kindred will reject them. (fg. 3)

The main concern about the disclosure of their condition in the family and community was related to the risk of stigmatization. According to Roma culture it is not appropriate to disclose personal failures or illness. When the family members learn the diagnosis they may try to keep it a

[89] A. Kleinman, L. Eisenberg, & B. Good, 1978, pp. 251-258.
[90] M. Pădurariu, A. Ciobîcă, C. Persson, & C. Ştefănescu, 2011, pp. 16-23.

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family secret, because, according to Roma social values, family shame should not be exposed.

Some patients may decide not to disclose certain medical symptoms that could be essential for establishing the correct diagnosis and treatment in order to avoid being judged by the physician or because of beliefs about what is appropriate to discuss with the doctor.

Not all communities share the same attitudes to illness or displaying symptoms. For this reason, the physician must avoid stereotyping and recognize that there are differences within each cultural group.

I have not encountered cases in my community when people hide their illness. So, people know he has diabetes... he is a terminally ill. They don't hide this. (fg. 2)

The doctor should be very careful and respect cultural the peculiarities of the community so that s/he can avoid conflicts with the family of his/her patient. HMs are the most recommended to prevent conflicts, as they know the community and understand traditions, filtering them through their own experience, shaped by prolonged contact with the majority's lifestyle and mentalities.

Family ties

Roma may live together in extended families, often under the same roof or close to each other. They value family harmony, and therefore personal identity is not viewed independently, but in the context of its relation to the family. When a member of the family falls ill and hospitalization is urgent, the others accompany him/her to the hospital, thus engaging the whole group:

I have a girl, in her twenties, who was operated for colon cancer and I can tell they were there, by her bed, at the hospital. (fg. 2)

A serious illness represents a social crisis that gathers the Roma close to the patient. This display of care for the patient represents one of the most important values in the Roma community. Fulfilling family duties is very important and prevails over individual interests.

The Roma patients or family may exhibit behaviours that do not conform to Romanian standards of behaviour. The participants in the focus group mentioned as a negative factor the large numbers of those accompanying the Roma patient, creating disruption and inconveniencies in the hospital. The HMs are convinced that these Roma, sharing the same values and traditions related to accompanying the patient in the hospital, encourage negative stereotypes about the Roma. They even reject this type of behaviour displayed by some members of this ethnic group that lead to the

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generalization of negative attitudes towards the Roma. Among such inappropriate behaviours they mention the lack of respect for medical professionals:

They are discriminated against because they don't always talk nice. If one speaks nice, doors open. (fg. 2)

When seeking medical care, some Roma ethnics consider themselves entitled to claim certain treatments and benefit from their rights as citizens. Their firmness in demanding these services often leads to conflicts with the medical professionals. These conflicts cannot be justified by ethnic differences between the medical staff and the patient, but by the latter's insolent attitude. When asked to say if it would be appropriate to have a doctor only for the Roma community, one of the HMs answered:

There are more issues. He'd say: "You, V., give me some medecine!" He's more problems. He'd come having courage, determination. (fg. 1)

Personal experience confirmed the HM's conviction. And yet, situations when Roma patients are respectful and compliant with the recommended treatment indicate the possibility of an effective partnership between doctors and Roma patients:

If I can behave, I can talk respectfully, first of all, to accept the idea that he is right...

Interviewer: Have you ever felt discriminated against?

HM: No, and I've got my kids. There are persons who share experience with me about doctors. "And what did you do? What did you say?" "Well, to prescribe that treatment!" "So, you'd better listen to him first, to tell you about your illness, don't tell him what to do, you're no doctor." (fg. 2)

While performing his activity, the doctor should use the authority of his profession and the status he has in the community:

He should be able to get respect, even using his authority. The bad thing is he doesn't have time for counselling. This is the part of the HM, at home, in the community. (fg. 1)

The HMs prove to have a good knowledge of the realities in the field, being able to evaluate situations: when the doctor is held responsible for the discontent of the Roma community that considers s/he does not make every effort to provide quality medical services or, conversely, when patients insistently demand certain services impolitely. Knowing the cultural environment of the Roma and the majority, HMs are helpful in a physician's activity and can mediate tense situations, guiding and advising the Roma patients to comply with the rules they should follow when seeking medical services.

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Disclosure of medical information to the patient

Individual autonomy represents the right of a person to decide for herself / himself, independently of any influence from other people. While the prevailing attitude of Western doctors is mostly patient-centred and focused on shared decision-making[91], in the Roma community, disclosure to the patient of a severe diagnosis is not common, for fear that it may harm the patient. The focus is placed especially on the principles of non-harm and benefit[92]. Most of the Roma consider that the family members should make decisions for them.

Somebody's dying. An illness that terminates him in a month, as it was the case with somebody in our community. He used morphine. He couldn't stand this. He didn't even know he was using morphine. And it was his family and the doctor who made this decision. (fg. 2)

Family members are typically involved in important decisions. The principle of individual autonomy is not universally accepted. Most of the Roma do not accept the individualistic model of decision making, but prefer the model of informed consent based on the inclusion of the family ("family-facilitated approach")[93]. The family-centred model for decision making is considered more appropriate, based on the idea that the patient is part of a network of family relationships and the smooth functioning of the family is more valuable than individual autonomy.

Often, however, it is difficult for physicians to evaluate the dynamics of the patient's family. When a HM is present in the community, the doctor can be informed about the values of the culture from which the patient originates. Although specific cultural values may be characteristic of various Roma groups, and health professionals should be aware of these features to provide patient-centred and culturally sensitive care, they must also recognize that not all Roma from a particular community adhere to the community's characteristic practices and values. Healthcare professionals should not assume *a priori* that, if the patient belongs to a certain community, s/he shares the values and beliefs of that community[94]:

[91] A Edwards, R Evans, G. Elwyn, 2003, pp. 33-38; J Harmsen, 2003; L. T. Beauchamp & F. J. Childress, 2001; LM. Pachter, 1994, pp. 690-694.
[92] S. C. Berkman & E. Ko, 2009, pp. 351-357.
[93] A. Ho, 2006, pp. 26-28.
[94] L. T. Beauchamp & F. J. Childress, 2001.

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In a community, not everybody agrees with each other. If they have a good relationship with the HM, they will know about the Roma's traditions, everything about us, they will be able to satisfy everybody's needs. (fg. 1)

Although the decision-making model is largely influenced by cultural values, the preferences of patients from the same culture can vary depending on income, education, religious affiliation, etc. Benefitting from the activity of HMs, healthcare professionals must determine, on the one hand, what, how, and when patients wish to be informed, and on the other hand, what, how, and when they wish to disclose their diagnosis to the family members. It is therefore not correct for the medical staff to assume that if a patient comes from a culture where the focus is on family and close family relationships, s/he would prefer family involvement in her/his healthcare decision. The disclosure of information and informed consent process must be flexible and adapted to each patient, rather than based on a rigidly individualistic or family-centred decision-making model[95], and should not violate patient autonomy.

4. Discussion

In an increasingly diverse society, physicians encounter more patients of different ethnic extraction and cultural backgrounds. The literature recognizes that minority group persons experience more difficulties in accessing and receiving adequate care in the health system and thus tend to underutilize it. These difficulties are even more relevant if we consider the fact that these populations are exposed to a higher level of risk factors for physical and mental health problems, such as encounters with discrimination and prejudice.

More than ever, there is a need for cultural competence, defined as the ability to transform knowledge and cultural awareness in medical interventions that support the normal functioning of the patient-system relationship in an appropriate cultural context[96]. Culturally sensitive practices are ways of professional intervention based on respect for the patient so that each patient receives similar and equal treatment, regardless of her/his cultural background, nationality, race or ethnicity, language proficiency, and socioeconomic status. This creates equality in access to healthcare and outcomes[97].

[95] S.C. Berkman & E. Ko, 2009, pp. 351-357; A. Ho, 2006, pp. 26-28.
[96] S. Maiter, 2009, pp. 267-276.
[97] E. Wu & M. Martinez, 2006.

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Several cultural competence models have been proposed in the literature. Campinha-Bacote[98] postulates that such competence includes: (1) learning to value and understand other cultures, in part through awareness of personal biases hindering this process (cultural awareness), (2) acquiring a basic educational foundation about other cultures (cultural knowledge), (3) the ability to apply cultural information in patient healthcare assessments (cultural skills), (4) gaining experience through cross-cultural interactions (cultural encounters) and (5) having the motivation to pursue all of the above (cultural desire). Campinha-Bacote's model thus has a strong focus on the individual provider. In their broad review of the literature, Brach and Fraser[99] formulate a comprehensive framework that includes both organizational and individual factors. Individual strategies include personal initiatives such as participating in relevant formal training and immersing oneself in other cultures. Organizational initiatives include the recruitment and retention of a culturally diverse staff and providing training opportunities as well as interpretive services.

Healthcare professionals must take into account cultural factors that might influence the Roma`s help-seeking behaviour. In Romania, during the communist period, the policy concerning this ethnic and cultural minority was to integrate it into the lifestyle of the dominant culture. After 1990, following the disastrous results of this approach, the Roma began to be considered from the cultural diversity perspective.

In providing health care to Roma patients it is necessary that health professionals be familiar with their specific health problems and social characteristics, that they understand there are many important cultural, religious and social factors that may arise in the negotiation and implementation of a therapeutic plan.

Professionals should give more importance to culture and its influence on identifying and defining health problems in order to solve them. Most care providers now recognize the importance of respecting the values and experiences of all members of society, starting from the premise that diversity and difference means that views, experiences and different perspectives deserve to be heard and valued[100].

[98] J. Campinha-Bacote, 1999, pp. 203-207.
[99] C. Brach, & I. Fraser, 2000, pp. 181-217.
[100] S. Maiter, 2009, pp. 267-276.

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A solution for the improvement of the quality of medical services provided to Roma patients is the involvement of HMs as *cultural brokers*. They are consultants who may provide information regarding beliefs about health, appropriate methods of communicating with members of certain communities, and problematic aspects in the interaction between the medical system and the Roma community. The continuous training of HMs is essential to responding effectively to the socio-cultural needs of the Roma communities, to facilitating access to the healthcare system and to adequately addressing the linguistic, cultural, social, and health status differences which affect the ability of Roma patients to properly use the formal Romanian healthcare system.

A key factor in improving Roma patients' access to the healthcare system is the community's involvement in the health policies aimed at the Roma population. In this way, healthcare services could be provided efficiently, leading to increased patient satisfaction and improvement in the quality of care. In addition, good relationships between the community and healthcare facility support the healthcare services provided to the community[101].

5. Conclusion

Despite the limitations of the study, our findings indicate that taking care of cultural specificity in healthcare is an ethical obligation. Patient characteristics such as ethnic origin, education, language proficiency and cultural views are important for developing a physician-patient relationship. A Roma patient`s obstacles to medical care include biases (e.g. racial/ethnic prejudices, social problems), limited language proficiency, low health education (the management of acute and chronic illness), lack of resources (e.g. insurance, funds for out-of-pocket expenses), fears (e.g. mistreatment, avoidance of stigmatization or serious diagnoses) or beliefs that pre-empt treatment (e.g. mistrust, aversion to medications and preventive care).

The findings of this study show that the physicians working with HMs in their medical team are more likely to have culturally sensitive attitudes and behaviours. This suggests that the existence of an HM in each Roma community is enhancing physicians' cultural competence, which may be synergistic strategies for reducing healthcare disparities. Physicians that have adopted more culturally competent practices may influence Roma

[101] E. Wu & M. Martinez, 2006.

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patients and carers to develop more civilised attitudes and behaviours in meeting their healthcare needs.

Because language proficiency is so important for a good evaluation of healthcare needs, it is recommended that we bridge the language barrier by making use of health or cultural mediators. They may advise the patients how to make use of the health services. In the light of our study results, it may be suggested that with guidance from the HM, the relationships between physicians and Roma patients would definitely improve. Similar studies point to the positive effects on communication, patient satisfaction and outcomes in the case of professional interpreters or bilingual providers[102].

The role of HMs in providing much needed counselling exemplifies one way of developing innovative, collaborative care and program building involving family physicians and hospitals, projects committed to the comprehensive and preventative treatment of the Roma population in Romania. Furthermore, this study shows that cultural differences between patients should not be neglected no matter how well-integrated the patient may appear to be. Physicians and other health care providers should be educated to be continuously aware of and sensitive to cultural diversity among patients.

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[102] G. Flores, 2005, p. 255–299.

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Rezumat:

Mediatorii din sănătate şi necesitatea unei abordări interculturale în cadrul comunităţilor de romi

România are o reţea de mediatori sanitari, meniţi să faciliteze comunicarea dintre comunităţile rome şi corpul medical. În acest studiu calitativ, folosind date colectate de la trei grupuri-ţintă cu mediatori sanitari din judeţele Iaşi şi Cluj, furnizăm informaţii semnificative despre aspectele problematice referitoare la populaţia romă. Principalele provocări sunt legate de barierele care afectează accesul lor la sistemul de sănătate şi de particularităţile acestui grup etnic. Accesul acestora la serviciile de sănătate pot fi îmbunătăţite prin dezvoltarea competenţelor culturale ale profesioniştilor din sănătate. Mediatorii sanitari sunt elemente-cheie în acest proces, cu atât mai mult cu cât ei pot realiza programe inovatoare de colaborare cu medicii de familie şi spitalele angajate în administrarea tratamentului şi acţiunilor preventive destinate populaţiei rome.

Cuvinte cheie:
Competenţă culturală, mediator sanitar, comunitatea romă, sistem medical.

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