Health Mediators – The Best Policy for Roma Integration in Bulgaria
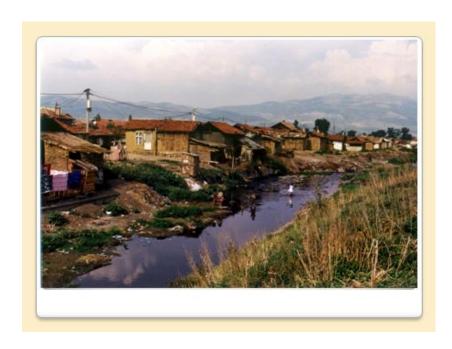
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Introduction

Historical Background:

The act of mediation, the attempt to resolve a dispute between two parties by intervening and arbitrating the conflict until a suitable decision for both parties is reached, has been a cornerstone in any flourishing civilization. Ancient Greece has been credited with the first use of mediators that helped resolve trade conflicts. From then onwards the mediator's influence has expanded drastically - laws on mediation were created in the Roman Empire which contributed to the mediator's growing status of respectable figures of society (Health Mediator). Furthermore, in eastern cultures, specifically Confucianism and Buddhism, mediators took over the role of wise men and played an extremely important role in the resolution process of communal conflicts.

New Meaning of Mediation and Its Types:

Nowadays, mediators have retained their inherited functions from the past. In the classical context they are important figures in diplomacy, law and other social spheres connected with conflict resolution. In the coming pages I would like to stress on another type of mediation, which is not so connected with peace and consensus building, but rather has a great impact on social aspects such as building bridges of confidence and integration between different ethnic groups on the basis of mutual understanding (Health Mediator). This type of mediation's growing popularity can be connected to the fact it is a relatively low cost, fast and effective procedure and also because there is a high level of conflict prevention. A specialization within a particular field of mediation -education, labour, health and culture - is commonly required because of the diverse nature of the critical issues and conflicts. Nevertheless, the frameworks with which a mediator has to work may constantly be overlaying; the most notable example mentioned below is the culture and health mediators(Health Mediator). Because of such overlaps mediators tend to have rudimentary knowledge of the other fields in question. The basic frameworks within which each type of mediator has to work are as follows:

Education mediator - deals with the desegregation of cultural and communal minorities into the school system by aiding in their completion of the school process and works towards the removal of language barriers in schools for an equal start in the educational system

Labor mediator – handles the processes of finding work for long term unemployed vulnerable groups and reintegrates people into the labor market

Health mediator – provides minorities with difficult access to health care with access to health service providers and health insurance systems, enriches the minority's health knowledge, motivates it in order to increase demand for health services and helps with the minority's integration by guiding service providers and government administration in their work and policy creation regarding vulnerable groups

Cultural mediator – assist emigrants and immigrants' integration into their new country of living by helping them in any way needed with the process of transition.

Europe and Mediation:

European countries focus on the latter role of the mediator in order to support members of marginalized communities – minority communities, apathetic to political change, suffering from societal exclusion in the form of employment difficulties, problematic access to healthcare, poor living conditions stemming from the state's negligence to support them and insufficient legislative measures protecting their rights and sovereignty (Health Mediator). Because of its great importance for all European countries, more specifically members of the European Union, newer member states such as Romania and Bulgaria have had to drastically change their multiethnic policies prior to their acceptance in the European Union.

Health Mediator Policy Critique:

The success of the health mediators has not come without some harsh but fair criticism from many fields of work. Economists argue that there is a need to establish a clear and unilateral standard for financing mediator activities as up to now the financing process has been divided between different ministries. By adopting such a regulation the mediators would be able to easily seek collaboration with different partners – institutions, NGOs and mediators from other fields. Scholars have also argued that the government's guidance of mediators should also be

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restructured (Health Mediator). The grounds for this argument come from the fact that the concept of mediation has been borrowed from other European countries. In those European countries the process of mediation is constantly evolving, something which cannot be said about Bulgaria's adopted model. A good example of the stagnation of the adopted model is the fact that other countries have embraced the idea that mediators work more efficiently when focused on specific projects rather than working in a broader field without a specific focus. Further criticism comes from experts in the field who also argue that the implemented model has a very weak governmental control, has poor or missing feedback from minorities, and lacks specific long-term goals. The final critique that has surfaced recently comes from the health mediator's impeded working capacity and overload courtesy of the fact that they have to deal various different institutions, their own community and the mainstream population (Health Mediator).

Problem Formulation:

My personal interest in this subject and my work experience with the health mediators has urged me to further explore this final critique. *The project will investigate the constraints and enablers of the various types of relationships and interventions that the health mediator has in selected Bulgarian municipalities with a high percentage of Roma and other vulnerable communities.* The research questions within this problem formulation are firmly connected to the definition of health mediator stated above and its duties. The questions are as follows:

1. How have the marginalized community's health status, social status and self-perception been acting as a constraint or an enabler of the health mediator's work? Why?

2. What is the attitude of service providers towards marginalized communities and to what extent have barriers between the marginalized communities and service providers been lifted in the light of the constraints and enablers health mediators have to work with?

3. What are the main attitudes of "mainstream population aka majority towards vulnerable groups and mediation and to what extent is there a degree of cultural recognition and respect between the mainstream population and the marginalized community?

4. What is the role of policies and policy makers at central and local level in the work of health mediators and the mediation process?

5. Are mediators recognized by the groups in need and what are the constraints and enablers in their counseling attempts?

I will be using three theories to estimate the constraints and enablers of the types of relationships that the health mediators have – broker- client relationship theory, Foucault's theory of governmentality and Bandura's theory of social learning.

It is important to note that the definitions of the important terms – mediator, government, service provider, mainstream population and marginalized community have been given throughout this introduction.

Methodology

Epistemology and Ontology:

The determinations of the epistemological and ontological considerations are other important factors of this research. The choice of epistemology has to be made between two opposing aspects – positivism and interpretivism. Positivism's main claim is the idea that human behavior can be explained (Bryman: 2012 page 28). According to this epistemology, research is carried out to confirm or reject hypothesis, a claim that connects this term with the deductive theoretical approach (Bryman: 2012 page 27). Furthermore, the epistemology's close relation with the scientific world and the prism through which it viewed the social sciences denounce the theoretical value of sources if finite observations on the subject at hand cannot be made. Because of that, some scholars believe that a more modern and less scientifically linked epistemology has to be identified. Such an epistemology is interpretivism whose main claim is the idea that human behavior cannot be explained, it can be understood (Bryman: 2012 page 28). This epistemological opposition is further enhanced by the idea that social research is vastly different from scientific research as in the former "social action is meaningful" (Bryman: 2012 page 30). Because of this idea of meaningfulness in the interpretivist epistemology, the social researcher must be able to understand the world from the perspective of the community he or she is researching. The epistemological stance that has been taken in this project is the interpretivist one as this research is not remotely sufficient enough to claim that it can explain any subjects in that area. Another argument for the use of the interpretivist epistemology is the main focus of this project – the relationships of the health mediator from the perspective of the mediator, a focus which deals with several abstract theoretical claims which will have to be omitted if positivist perspective is adopted. As the choice of the epistemological position, the choice of ontological position also has to be made between two opposing aspects – objectivism and constructionism. The objectivist ontology claims that "social phenomena and their meaning have an existence that is independent of social actors" – social order is predetermined and cannot be modified by the participants in it (Bryman: 2012 page 33). Opposing this ontology, constructionism "is an ontological position that asserts that social phenomena and their meaning are continually being accomplished by social actors" - social order is constantly altered by its participants (Bryman: 2012 page 33). Based on this information, the type of ontology chosen in

this project is constructionism as the investigation of the relationships that health mediators have is based on the principal assumption that these relationships can be changed for the better work of the mediators, an idea that is not possible through the ontological prism of objectivism as the social order within which the mediators work with is regarded as concrete.

Theoretical Implementation:

The next logical step after having found practical theories and relevant sources for this particular research is the selection of an approach of theoretical implementation. There are two possible choices regarding this matter - choosing an inductive or deductive approach. The general orientation of the deductive approach is that it presents the idea that prior to starting a research a lot of background information and theories related to the research at hand must be accumulated in order for a testable hypothesis to be formed. After the formulation of the hypothesis has occurred, data is collected and analyzed in order for the hypothesis to be tested. According to Bryman the final process in this approach upon confirming or rejecting the hypothesis, "the researcher infers the implications of his or her findings for the theory that prompted the whole exercise", a process formally known as induction (Bryman: 2012 page 24). A choice of using this approach usually entails the use of quantifiable data and is considered to be less than optimal with the use of qualitative data as the biggest asset of using this approach, its chronological order, is lost due to the possibility of the emergence of new important aspects and links. In the case of this project, a research which requires the collection of qualitative data the choice of which will be argued for in the upcoming paragraphs, the appearance of new links is eminent - the addition of the social network theory into the theoretical framework was made as further mediator relations emerged that could not be explained by the previous theories (Bryman: 2012 page 25). Because of such analytical limitations imposed by the use of the deductive approach, the approach chosen in this research is the inductive one. The inductive approach permits the collection and the analysis of data without the formation of a hypothesis as the hypothesis is made based on the analysis of the collected data and the theories (Bryman: 2012 page 26).

Approach to Data Analysis:

An obvious shortcoming of the choice of inductive approach mentioned above is the fact that researches do not always have the ability to formulate theories as the research produced can be considered an empirical generalization (Bryman: 2012 page 27). Because of this problem, a suitable approach to the analysis of data has to be chosen to boost the research's chances of formulating a hypothesis. One main strategy that has to be considered regarding the analysis of data is analytic induction. This strategy calls for the formation of a hypothesis which is constantly revised to exclude all cases of inconsistencies through the collection of additional data (Bryman: 2012 page 567). Because of the nature of this strategy, the process of data refinement can be a time consuming task as newer and/or inconsistent variables can constantly appear − a complication that will further delay and possibly limit the chances of formulating a hypothesis (Bryman: 2012 page 567). Another main strategy that has to be considered is grounded theory − an approach which aids the process of generating a hypothesis by utilizing an iterative approach, the constant analytical movement between theory and data in order to ensure their close relationship (Bryman: 2012 page 26). The use of grounded theory also creates specific guidelines in other parts of the decision making process such as sampling, interviewee group size, coding etc, the purpose of which is to ensure the close proximity between theory and data to further help the creation of a hypothesis . Such guidelines make grounded theory the preferred analytical strategy.

Research Design:

After having chosen a data analysis strategy, the next important step in assuring a high quality of research was the selection of a proper research design that would best fit the qualitative research strategy. This can prove to be an arduous task as each research design presents a different method of conducting research, and each method has a different level of compatibility with the research of this project. For example, the implementation of an experimental research design would create the opportunity of collecting data through the creation of experiments (Bryman: 2012 page 50). This particular design is seldom used by social researchers as the design is not considered fruitful with the exception of studies regarding social psychology and organization studies (Bryman: 2012 page 50). As the subject of the research in this project is not remotely connected to the fields mentioned above, adopting such a research

design will not be considered useful. Another type of research design that could be adopted for this research is the case study – an in depth analysis of a specific community, family, organization, person or event (Bryman: 2012 page 67). Since the health mediators work in different Bulgarian municipalities with different communities, this can hardly be considered a case study. A further type of research design is called the comparative design – a design which requires two or more distinctive cases which are analyzed using similar methods (Bryman: 2012 page 72). This research design also does not fit the project's main subject of exploration as the mediators' relationships do not differ from municipality to municipality. The last research design considered for this project was a cross-sectional design as a longitudinal design was not applicable because it requires the collection of data through a long interval of time which does not fit the time frame of this project (Bryman: 2012 page 63). The adoption of a cross-sectional design implies the use of surveys to determine the relationships between identical variables in separate cases (Bryman: 2012 page 59). The adoption of this research design was eminent as the applicability of this research design to the research of this project is very high because similarly to the basic idea of the research design, the main idea of the project is to highlight the links between the variables - the different relationships that a health mediator has - within different cases, the distinctive Bulgarian municipalities.

Sampling:

As only one type of survey is used within the research, the process of determining the number of interviewees and their sampling is decisive for the high level of authenticity of the research. It is evident that a type of purposive sampling must be utilized as a specific group of people must be interviewed. The way in which the interviewees were found to a great extent resembles snowball sampling – the researcher relies on a small group of primary interviewees, in the case of this research three, to recommend and convince other people to partake in the research (Bryman: 2012 page 424). This type of sampling generally requires the use of an additional sampling approach to refine the collection of the data (Bryman: 2012 page 427). Out of the two types of purposive sampling left, generic and theoretical, a choice was made for the latter as generic purposive sampling although very similar to theoretical sampling does not include one of the main strategies of grounded theory- the iterative strategy of constant movement between theory creation and data collection which is present in this project through

the use of separate semi-structured interviews (Bryman: 2012 page 422). This decision introduces the idea that theoretical saturation must be achieved – a concept which entails the improbability of new theoretical variables to be generated by the collection of more data (Bryman: 2012 page 421). Achieving theoretical saturation can be considered an infinite process as newer and newer concepts can constantly emerge. This is one of the reasons theoretical saturation is closely related to the size of the interviewee group as the researcher must decide when an acceptable level of theoretical saturation has been attained, a unique decision for each project. Guidelines concerning this decision were made in Guest et al's research about the high threat level of HIV contraction for women in two African countries in which Guest et al argued that because of the homogeneity of the interviewees and the finite research capacity 92 per cent of variables were introduced in around the first twelve interviews (Bryman: 2012 page 426). As the scope, the relationships that the health mediators have to deal with, and the homogeneity of interviewees, the health mediators, in this research are also very limited, the benchmark for the number of interviewees is roughly the same as in Guest et al's research – ten.

Validity and Reliability:

With that final clarification a thorough methodological description of this research has been created. However, a further discussion of the evaluative criteria- validity and reliability - and the limitations of this research must be made (Bryman: 2012 page 46). With regards to the criteria of the evaluation of social research, reliability is concerned with the repeatability of the research and the consistency of the data (Bryman: 2012 page 46). It is generally difficult to attain a high level of reliability in qualitative social research as the social environment of the research's participants is constantly changing (Bryman: 2012 page 390). This is particularly the case with this research as new governmental policies constantly reshape the societal order of the health mediators. The criterion of validity has three categories connected to qualitative research – internal validity, a type of validity which assesses the connections between concepts in the research, external validity, a category of validity concerned with the possibility of the generalization of the findings, and ecological validity, a form of validity which assess the applicability of the research's conclusion based on the level of intrusion in the interviewee's social order - to evaluate the overall integrity of the research's conclusion (Bryman: 2012 page 48). The two main methodological decisions made within this chapter that directly influence

validity are the choice of research design and the type of collected data - qualitative. The internal validity of this research is at first glance weak as the implementation of a cross-sectional design establishes associational links between the concepts (Bryman: 2012 page 60). The basic assumption of this research however is that it has strong internal validity as the researcher has spent a lot of time within the social order of the mediators prior to this research and as the method of respondent validation – the act of providing the interviewees with the findings of the researcher for their approval -has been implemented with high results (Bryman: 2012 page 390). A low external validity is to be expected of this research, a claim contrary to that of cross-sectional design, as the researcher employs a small interviewee groups and purposive sampling – two methods which disable the probability of creating a generalization (Bryman: 2012 page 390). Last but not least, the ecological validity is strong in some point of assessments and weak in others - the interviewee's were not removed from their social surroundings as the interviews were done through Skype, an indicator of strong ecological validity, however the implementation of semi-structured interviews disrupts their social order (Bryman: 2012 page 61).

Limitations:

Because of the research's focus on the relationships that the figure of health mediator has from the perspective of the mediator, the limitations regarding this research will revolve around the inability of the researcher to include and/or analyze specific relationship connections between different actors around the health mediator even though they are elaborated on by the theoretical scope. Such relationships include the relationship between the government and the service providers, between the government on a national and municipal level, between the service providers and the mainstream population, between the government on both a national and municipal level and the mainstream population, between the government and the policy makers and between the policy makers and the mainstream population. The addition of these aspects will undoubtedly create a more compelling research, however as they are not backed up by the collected data, their inclusion would generate critique rather than appraisal.

Theories

Theory of Governmentality:

The introduction of the term governmentality has been credited to Michel Foucault, a French philosopher exploring the sphere of political power. In order for the reader of this research to understand the meaning of governmentality, Foucault's definition of government must be examined. He defined government as "an activity that undertakes to conduct individuals throughout their lives by placing them under the authority of a guide responsible for what they do and for what happens to them". The basic idea behind his definition is that the government can control an individual's actions with the use of laws and policies that the government creates (Rose: page 83). This type of governance has been utilized since its appearance in the eighteenth century after its evolution from a type of government which saw universal virtues as the main principles of governance and is formally known as state reason. State reason is a type of governing characterized by the will of the state to strengthen itself by creating favorable conditions for its accumulation of power achieved through the process of supervising the actions of individuals. With the implication of the state reason, a movement that would be regarded as a catalyst for the evolution of governance was formed. The main factor of this movement was the development of a sense of population by individuals – "forming a kind of natural collectivity of living beings". The appearance of the sense of population is a catalyst which is still influencing the evolution of the types of governance by developing new constraints and enablers in that field. Because of such catalysts as the establishment of group characteristics over those of the individual and the government's need for explicit knowledge when dealing with the characteristics of a specific society (Rose: page 84) Foucault has easily managed to define governmentality as "an ensemble formed by institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this very specific albeit complex form of power . . ." (Rose: page 86). The essence of this definition is the idea that a liaison is made between governing and the effect it has on members of the population.

One of Foucault's major points of interest in the development of the term governmentality was the political philosophy of liberalism, a theory which explored the equality and the freedom of individuals. The application of liberalism into the theoretical framework of

governmentality was seen as its logical continuation, not as a framework. The main reason for this conclusion was the opposition of perspectives between liberalism and state reason – both of the theoretical frameworks agreed upon the idea that individuals needed to be governed by the state, however liberalism included the state's population as a continuation of the state. According to the liberalist doctrine, the government had to take into consideration the different types of relationships that an individual could have and their respective complications from the exterior (Rose: page 87). For this reason liberalism was regarded as a protector of society's interests and a critique on disproportionate governance (Rose: page 84).As a link between governmentality and liberalism had been ascertained, and as the popularity of liberalism continued to grow, governmentality became a cornerstone for the contemporary structures of political theory (Rose: page 86). The important connection established between governmentality and liberalism has also shed light on a new perspective of governmentality never explored before – the state is not the only institution responsible for the creation of policies and laws that have a direct impact on the populations. With the introduction of liberalism different institutions manage different aspects of an individual's life with different objectives. This internal division of the population creates subgroups with different judicial interests which in term makes the creation of policy from any institution an arduous task (Rose: page 85).

Another aspect of research that has highlighted Foucault's connection between governmentality and liberalism is Nikolas Rose's work on the ethics of governmentality –how an individual comprehends and acts within a certain political framework. Previously, it was considered that acts of personal freedom were done to protest against the government's political structure as it was believed that the government can easily take an individual's freedom away. As opposed to preceding researches in the field, Rose dismissed the inclusion of social criticism in his ethical analysis of governmentality as nowadays the soul, the symbol of freedom, was the most important vessel of governance. The government promoted this vessel of governance, connected with the liberalist political dogma, as any type of personal freedom was viewed not as a privilege but as a right and a responsibility (Rose: page 90).

It is also important to note that Foucault's research has been fruitfully utilized in many different spheres such as social work, the economy and culture (Rose: page 97). Despite the intellectual fertility of the term governmentality, one can come across criticism of the topic.

Firstly, some scholars view governmentality as an idea which is overly abstract and difficult to grasp (98). Furthermore, in order for governmental programs to be analyzed thoroughly through the frame of governmentality a division of governmental eras based on philosophical influences may be needed to be made. Such division however is seldom possible as a researcher cannot differentiate single influences of political philosophy (Rose: page 99). Last but not least, as Rose puts it in his research "governmentality is guilty of homeostasis—that it provides rigid models of government that are so systematically integrated that change must be accounted for from elsewhere" (Rose: page 98).

The concept of governmentality is playing a considerable role in this case. After being an NGO pilot initiative, funded by the PHARE program of the European Union, the health mediators in Bulgaria became, after 10 years of advocacy efforts, a real state policy that have been recognized by institutions and supported by municipalities and state budget. It is a very good example of how civil society can influence political thinking. Furthermore, the practices of the civil society can prove useful as they can be converted and replicated – because of the good social practices of the Bulgarian society and the good political practices of the Bulgarian government this model is actually being implemented in neighboring countries as Serbia and Macedonia with the help and expertise of Bulgarian authorities. The mediators are a wonderful communication channel and dissemination instrument of state policies. The relationship between the Regional Health Inspections and the Roma population, between the service providers and the vulnerable communities and between the municipality and the problematic districts just emphasize the importance and right use of governmentality as the latter in each of the three cases wants to be included in the governmental policies. On another hand, there is always a risk of misusing the mediators for political purposes - there are reported cases of attempts of using them during elections for achieving personal political interests instead of the dissemination of good practices. Preventive mechanism must be installed in order to protect the blooming of such cases, however a long time must pass before the implementation of such policies. This final negative connotation proves yet again the importance of governmentality in the context of health mediator's work.

Patron-Broker-Client Relationship theory:

A divisive categorization of the relationships that mediators have with other actors in their social order has been made – client patron relationship and broker client relationship. The former was first identified by John Davis who assumed that specific groups had some kind of leverage, usually political or economic, over other groups within their social surroundings (Patrons and Clients). He identified that this superiority within that relationship is held by the patrons while the group that actively sought the patron's power were known as clients. It further has to be noted that the exchange made is reciprocal however asymmetrical and is not tied in with the state. One of the most important aspects for the creation of such bonds is the reputation of the patron as the relationship is based on trust. It is also quite common in these types of relationships for the client's society to be very tight-knit and to rest its strength on family ties (Patrons and Clients). However, because of the nature of relationships in general some type of bond has to be formed – the bond of "spiritual kinship". This is a supplement to the traditional layers of kinship in the client community in which the client pays respect to the patron by offering him gifts or giving him important family positions such as the position of godfather.

As opposed to Davis, Gilse-nan, a follower of the Marxist school of thought, argues that this type of relationship is too idealistic because the relationship between patron and client is not a personal one but rather a relationship based on structure and class. Furthermore, this type of relationship can only take place in places with a low level of governmental control or high level of turmoil (Patrons and Clients). For example, the Italian mafia served as both patrons and clients between peasants and landlords in the 19th century, a time in which Italy had high political turmoil. Additionally, the need for a patron client relationship is not high today. The decline of its importance however is not based on its dysfunctionality. It is based on the expansion of the government's functions and the inclusion of different communities into their policies (Patrons and Clients). Although rare, patron client relationships are still seen today in severely marginalized communities.

With the evolution of structural control administered by the government, a development was also seen in the patron client relationship. Robert Pain introduced the term of broker – an actor in the communication process which has some kind of superiority over the client, however

he or she does not use this power for personal benefit but keeps the interests of a third party. This type of relationship is equally beneficial for everyone - as brokers encourage their weak clients economically and politically, the third party receives the appraisal from the broker's action and the broker receives dividends from the third party. The biggest fluctuation from the patron client model is the fact that there is a form of regulations in the relationship (Roniger: page 16). The client broker relationship has specific criteria for the need of regulation - power access, resource allocation readiness and mutual responsibility. Additionally, a very strong connection must be established between the client and the broker right from the beginning as the client must be led to believe that the broker must be principally loyal first to him. An easy way of creating this connection is by establishing a common background between the client and the broker. If one or more of the criteria mentioned above is not fulfilled by the broker, clients can show their unsatisfaction by boycotting him. By doing so the third party, is faced with the dilemma whether to lose their appraisal and dividends, or to regulate the broker's actions to some extent (Roniger: page 21).

Paine also identifies the problems with his theoretical framework. In the broker client relationship, the proxy has difficulty working with a high level of efficiency as there is a patron client relationship established between him or her and the third party. This type of relationship as mentioned above is somewhat limiting to the client as the third party can exert too much uncalculated control on the actions of the proxy, an expert in his field of work (Roniger: page 23). Furthermore, all three types of actors are easily corruptible, a detrimental feature to the broker client relationship.

Mediation is the core approach in the process of communication between the vulnerable and mainstream community. The relations between mediators and the vulnerable community are demonstrated very well by the "broker - client" relationship. The mediator as a typical broker is familiar with the environment of the client, possesses more skills and knowledge in certain fields and communicates them to the client – the vulnerable communities that need information, motivation, guidance and support in order to understand health prevention, usefulness of immunizations, Pap smears, and hygiene matters. The government sees health and sexuality education as especially successful in vulnerable groups based on the mediation principle of "selling" new information and innovation. This connection between the government and the

health mediator's resemble the idea that brokers keep the interest of the third party as the government gets appraisal in the form of social control and amiability from the respective community due to the mediator's work in that field.

On another hand the relations between government and mediators as "ambassadors" of the vulnerable communities is a very good example of patron – client relationships. At first glance the government uses these channels in order to install and improve social and health policies and disseminate messages that support the vision of the political class for development - something which supports the idea that this relationship is a broker client relationship. The perception of this relationship changes once the dynamics of power are viewed. As the government holds most of the power, the mediators have to be subordinate to it even if they are the experts in that particular field – a trait which resembles the connection between patrons and clients.

With regards to service providers, the mediators generally have to present the concerns of the marginalized community. This type of relationship also highlights a broker client relationship between the mediators and the marginalized community as the mediators protects the interests of the community.

Social Learning Theory:

The method of peer-to-peer education is quite popular in the last decades. It has been used to combat substance abuse and nicotine addiction and organize self-help groups for women, young people and vulnerable communities. In the last twenty years there has been a growing trend of using this method in health and sexuality education for raising awareness and providing information on topics such as HIV and contraception (Turner: page 236). The settings within which peer education is used have expanded drastically – previously peer education was only established in educational facilities, but now the scope of settings includes communities outside of schools (Turner: page 236). This expansion into different fields and different settings can be attributed to the attractiveness that peer education possesses and to the instinctive empathy that people with similar age, lifestyle, social strata etc. express one to another.

A validation of the peer education method is easily made by looking at the positive aspects surrounding it. If a focus would be made on the peer educator, he or she would be credited for being an authentic supplier of information, for being a role model for the community in question, for being an educational enforcer through communal contact and for being good at diffusing information in the community, a task which cannot be accomplished by outside professionals as it is hard to gain the trust or to apply conventional methods to the community (Turner: page 237). Furthermore, the peer education process is considered to be advantageous for the peer educator as a sense of empowerment is developed during the participation in the education process (Turner: page 237). Last but not least, the cost of implementing this educational method is lower than that of other methods (Turner: page 236).

A theory which has been widely connected with the positive aspects of peer education method is the theory of social learning developed by Bandura. The central idea behind this theory revolves around the idea that the education process in any setting runs more smoothly with the introduction of a figure which the participants in the learning process can look up to – a role model. The level to which the participants will model themselves after the peer educator depends on several different features interconnected between each other. Firstly, the virtues that a peer educator does or does not possess and his/her social status within the community have a tremendous impact on his or her ability to successfully be a role model as the higher the social status of the peer educator, the bigger his influence in the community (2 Turner: page 37). If the

peer educator is able to fulfill the requirements mentioned above, he will be considered a trustworthy source by the community which will enable him to take the position of role model. The peer educator will then have to develop strategies of reinforcement in order for the participants in the learning process to recognize the good practices.   The strategies of reinforcement are divided into two types of categories – the first being positive and negative which ultimately achieve behavioral change with different means, and internal and external (Grusec). The difference between the latter categories of reinforcement is that in the case of external reinforcement approval comes from exterior sources while internal reinforcement is the feeling that one experiences from being accepted and approved.

The role of the peer educator as a role model is further emphasized by the type of information he or she spreads – the peer educator does not simply constitute facts, he or she supplies social information modified specifically for the needs of the social strata, a task which requires a high level of confidence in the presentation of this specific information (Turner: page 238). The relation between the level of confidence and the presentation of social information is developed as peer educators have to oppose pressures exerted on them by their own community. In order for this opposition to take place, the peer educator has to behave in a way which he was trained to by his trainers and instructors - to be assertive (Turner: page 239). The type of information the peer educators spread and their societal function as role models however make it difficult at first glance to educate members of the community about topics such as HIV and contraception as the participants cannot model themselves after their mentors (Turner: page 238). As opposed to these arguments, Kelly at al's research in this field speculated that peer educators could indeed have influence in this type of field. Their investigation revolved around the sexual reproductive health habits of gay men in three American cities. After the introduction of peer educators, a decrease was noted in the transmition of the HIV virus within that community (Turner: page 238). Furthermore, the research showed that there had been a decrease in the number of peer educators that practice unprotected sex. Findings such as this emphasizes the fact that there is a connection between the theory of social learning and the qualities of peer-to-peer education as the peer educator has benefited from his or her job through the accumulation of new qualities or through improvements made to his own life (Turner: page 239).

The theory of social learning has also been justifiably critiqued. As opposed to Bandura, Klein claims that the important characteristics of the peer educator cannot be cultivated as a person is born with them (Turner: page 240). This claim creates the major division within this theoretical framework as supporters of Klein render the process of training peer educators ineffective not only because of the argument mentioned above but because the training process administered to the peer educators distances them from their community as they are influenced from outside experts not acquainted with the specific community (Turner: page 237). A further problem is seen in the peer educator's use of negative reinforcement due to the fact that this type of reinforcement can discredit his influence as it discourages the individuals he or she is trying to teach. Lastly, a high level of consistency must be present between what the peer educator does and what he teaches as such discrepancies denote his influence as a role model (Turner: page 237).

The mediator is a very good example of peer educator as the recruitment process for mediators follows a sound criteria – they must be members of the vulnerable community they will serve, they must know the language of the community and they must have knowledge on the main problems, the health status and the peculiarities of the group. This makes them "experts based on experience" and facilitates the exchange of the information flows in a suitable language with the use of appropriate health messages. At the same time other criteria such as minimum high school diploma, excellent communication skills, training on health mediation and certification form a Medical College makes the mediators able to be good communicators and educators of tolerance to service providers. Additionally, the level of integration of the peer educators - the fact that they follow the "general characteristics and rules" of mainstream community such as integration, educational level and employment makes them "peers with special expertise" in the eyes of the majority and their own community. In other terms, the mediators are unique peer educators deeply recognized as such by their communities. Last but not least, health mediators are considered as peers by the mainstream society – based on their demonstrated level of integration and following of the "general rules".

Analysis

Question 1:

The marginalized communities best describe themselves as entities of individuals lacking perspectives. Almost all of the interviewees mentioned this problem in some form or another - they said that the communities „are desperate from their life", they "expect to be saved" and "need help for everything". They further elaborate on this problem by using the word "forgotten" in terms of governmental care as there is "a lack of information and resources" and "health insurance is unreachable". As the marginalized communities perceive themselves as "open to change", an idea mentioned by several interviewees, a constraint for the work of the health mediator arises with regard to the theory of governmentality – members of the marginalized community may not want to take advantage of the presence of health mediators as they do not see how this interaction can change their existence as they are led to believe by their surroundings that the government does not treat them as an extension of the state but rather as something external and unwanted. Although an argument can be made that this is not the case as the government provides the members of the community with social benefits some of the interviewees stated that this is not enough. They argued that the marginalized community required a more "proactive approach" than social benefits - another example of a constraint that this relationship between government and the community has on the work of the health mediator. The interviewees further expressed their concerns in this area as they saw members of their communities as actors in a "vicious circle". Such vicious circles are inherent – a factor which further shows the government's unwillingness to aid the marginalized community (or shall we wrong prioritizing and lack of understanding on the issue). This creates further unwanted strains between the mediator and the individuals who he or she is trying to help.

Another problematic factor in the relationship of the health mediator and the members of the marginalized community is their different prioritization. Several of the interviewees touched upon the idea that most of the individuals in their respective community, especially the youth, are financially driven. These individuals do not pay attention to their health as they perceive it to be "given from Destiny". This puts the health mediator in the position where he has to raise health awareness - in a way he or she has to remodel the priorities of communities, which as

described by the interviewees are very "capsulated communities" with limited outside influence. On top of this if we look from the perspective of the social learning theory this creates a problem because the community's peer educators, the role models of their respective societies, are trained mainly by outsiders. As the mediators have been influenced by the outside, they may be discredited while trying to implement change.

It is important however to also note that the interviewees did not only criticize their surroundings. They also stated that forms of governmental evolution have started taking place. The interviewees started that in some municipalities the government and government employees help the marginalized community by performing checkups on "people without health insurance". As this practice is more and more adopted the mentioned above community interest to be "open to change" are proven again as the members of the community start to pay attention to their health. This example can directly be related to the theory of governmentality as the government understands that the implemented policies regarding the marginalized community will affect the positive conduct of the marginalized society as the government considers the vulnerable community as its extension, as part of it.

Question 2:

Upon looking at the collected data there is an obvious division between the health mediator's opinions on the matter of service providers. Half of them believe that the work that their service providers are doing cannot be substantially critiqued, while the other half believes that service providers need to be further educated in the matter of dealing with marginalized communities. Despite of this difference, the general opinion of both groups of mediators is that they are reciprocally helpful to both the service providers and the marginalized community. With regards to the relationship that the actively seeking help portion of the marginalized community has with the service providers, the health mediators act as form fillers, "translators", givers of advice and encouragers. With regards to the broker-client relationship theory, the mediator is the broker of his respective community as he vigorously assists them in their relationship with the service providers. From the analysis of the collected data it is also visible that the health mediators also help the service providers in their work with the marginalized community as they "establish connections" between the two parties and they facilitate the work of the former. The group of mediators that believes the current arrangement between service providers and the marginalized community should not be changed states through comments such as "they started spontaneously to seek my support" that the service providers impulsively want to provide service to the marginalized community. If that conception is perceived to be true, according to the broker-client relationship theory health mediators are brokers of the service providers as they work with the marginalized community to "attract" them to the service providers, to create demand. Refracting these two relationships through the theoretical prism of governmentality again shows that the members of the marginalized community are part of the "national population" as they are affected positively by governmental policy.

With regards to the other group of mediators, the ones that critique the service providers, a broker client relationship cannot be established. This is partly because these mediators do not believe that the service providers are accepting patients from the marginalized community willingly. These mediators have noticed that service providers give "poor quality services" to members of the marginalized community and "are trying to take money for people with health insurance". These mediators indirectly have also stated why this phenomenon occurs – they feel the service providers are not competent, are corrupted, use stereotypes, do not tolerate

differences and do not respect other ethnicities. With regards to the theory of governmentality, the perspective of this group of mediators shows another constraint in the relationship between the mediator and the marginalized community as it is very easy for the individual from the marginalized community to feel unsupported by the government.

The second group of mediators also expresses their opinion that there is tension between the health mediators and the service providers. This tension namely comes from the fact that according to the mediators the service providers felt supervised. When looking at this through the prism of the broker-client relationship theory, the mediators are acting as brokers for the marginalized community, an idea which is bound to make the marginalized community feel included by the government from the perspective of the theory of governmentality. However, the health mediators are also at the same time rejected by the service providers because as one of the interviewees said "people do not like to be supervised". This idea was repeated by many interviewees as they believed that the service providers resented the mediators as they actively searched for their mistakes with the potential menace to report these mistakes. While looking at this relationship through the theory of governmentality, similarities can be found with regards to state reason - through their municipality employees from vulnerable communities the government wants to control the service providers in order to create for them favorable conditions for the smoother integration of the marginalized community, an idea the service provider may not support.

Question 3:

The mediators were not able to unanimously select a specific attitude with which the "mainstream population" perceives them. Instead they had unconsciously and logically divided the mainstream population's perspective into two categories –positive and negative. The positivist remarks that were received by some mediators such as "catalyst of change" emphasized their quality of work, more specifically their ability to help the marginalized community. The most encouraging comment on which the interviewees emphasized upon was the fact that some members of the mainstream community sought help from them. It is very easy to estimate the high level of social approval some of these mediators possess by looking at this statement through the theoretical framework of the social learning theory – members of the mainstream community see the health mediators as role models in a particular field, an enormous compliment that validates the effort that the health mediators have put into their work. However, even as these mediators helped members of the "mainstream population", they are not regarded as being an integrated part of it. Most interviewees described themselves as being "educated""outsiders" in consideration to part of the mainstream community that accepts them. This separation does not only exist because of the perception that parts of the mainstream population has on health mediators. Some of the interviewees also named themselves as being "others" – they make a distinction between themselves and the marginalized community. With regards to the social learning theory, this practice is detrimental to the success of the mediator's work as he no longer sees himself or herself as a peer. Additionally, the members of the mainstream community that have a negative sentiment towards both the marginalized community and the mediators perceive any individual from a marginalized community through stereotyping and different forms of prejudice. Upon looking at these characterizations made by the majority population through the theoretical prism of governmentality, it can be assumed that there is a conflict of interest between the part of the marginalized community that wants to be integrated and the members of the mainstream population that want to keep Roma people out of reach of governmental policies and/or wants to keep Roma people as separate entities with regards to the mainstream population under the pretenses that "Everything is for Roma, all services and programs focus on Roma, we suffer because of them, they have to be isolated, they have to be terminated". The uniqueness of this conflict is presented in the government's inability to react well to it - governmental policy cannot be legislated as it will hurt one of the two groups.

However, due to the bigger size of one group, the other's interests are trampled. As the choice that is made by the government is clear to the marginalized communities, the marginalized community again strains the relationship with the only governmental employee that tries to help them and protects their interests. Furthermore, if the mainstream population has to admit the obvious qualities of the health mediators, they do it not under the form of appraisal, but opposing mediators achievements to the marginalization of the vulnerable group – "it is not valid for you", "you are not like them" which irritates them in a passive aggressive way. This shows the belief of the majority that the exceptions confirm the general rule.

Some of the interviewees however have stated indirectly that a change in the perception that members of the "mainstream population" have on the marginalized community is something achievable. This process of developing likeability for the members of the marginalized community is facilitated by the mediators completely. The process of developing likeability can be analyzed through the prism of the broker client relationship theory where the health mediators act as brokers for their marginalized communities. The brokers promote the Roma community by dismissing stereotypes such as the fact that they are "illiterate, uneducated and living on the back of the government". They dismiss these prejudices by trying to explain to the members of the mainstream population that "among Roma, there are honest educated and working individuals".

Question 4:

The interviewees expressed very clearly two major concerns that they have when dealing with the government at a central level with regards to their own well being. They stated that they have to function in very poor working conditions and furthermore expressed the need for the government to raise their salaries in order to be treated equally with other individuals hired by the government, a sign of governmental discrimination. Some of the mediators voiced their concerns by stating that "mediators are used to clean the windows when needed" and that "subsidies for travel to the needed destinations" are lacking. In consideration to their work they also pleaded that the government supplies them with more information and increases its participation in their work. Looking at these concerns and recommendations through the theoretical prisms of both the theory of governmentality and the broker client relationship theory it is easy to assume that the health mediators appeals for the further inclusion of the government in their work as they are brokers of the marginalized community and want to facilitate their inclusion in governmental policy, a favorable act when looked through the prism of governmentality. However, as the health mediators act as brokers for the marginalized community, they also have to act as brokers for the government, the reason for their primary implementation. Since the more enthusiastic party from the perspective of the mediators are themselves, the government wants to "regulate" their eagerness. The health mediators imply that this regulation takes the form of economic and facilitational discouragement – according to the mediators this is done in the form of unpaid work periods and acts of taking away the mediator's civil liberties in the work place such as heating, Upon reflecting on the government's deeds through the patron client relationship theory, one can easily conclude that the government acts as a patron who does not use their power to make the mediators gain leverage but rather uses it to punish them. This creates unfavorable conditions for work according to the social learning theory as negative reinforcement is not perceived well by the members of the marginalized community - it creates intrinsic gated communities.

The health mediators are much more content with the work that the government officials do on a municipal level. They identified several such services that aided them o n a day to day basis – the municipality itself, the regional health inspections and the social support services. This positive collaboration between these governmental institutions and the health mediators are

a great example of the theory of governmentality in action as the wish of the marginalized community to be integrated is met by decisive actions from the appropriate institutions. Upon analyzing the collected data an interesting and unexpected conflict was established –between government officials of municipal and central level. Sadly, the provided data from the interviews has not cast any light on the subject, however this specific relationship between the municipality and the central government should be further explored as a separate research revolving around the same thematic.

Question 5:

All of the interviewees believe that the majority of the marginalized community perceives them as "helpers". Some even mentioned that they were praised as "saviors" of the community. The mediator's perception of being highly recognized and respected corresponds with the social learning theory's main idea – trustworthy peer educators can best reshape a community. Some of the mediators however expressed their concern that members of their marginalized community invest too much hopes in them.   This overinvestment creates unrealistic expectations that cannot be fulfilled by the mediator. Looking at this phenomenon with regard to the theory of social learning and governmentality, the mediators and the government may respectively lose influence or aid in the process of gating a community through their presumable inefficiency to resolve problems. Additionally to these two perceptions, there are members of the marginalized community that have hated health mediators from the start of their work. The interviewees say that such individuals are rare however dealing with them can be considered a strenuous task as they sabotage the work of the mediator for no reason, an act that may result in the change of the community's health mediator if viewed from the perspective of the broker client relationship theory – as the client is unhappy with what his or her broker does he has the right to boycott his actions. In most cases however this hatred can easily be explained upon looking at the theory of social learning – as the mediators were trained by outsiders of the community they themselves are not to be trusted. Nevertheless, as the mediators have variously pointed out, the marginalized community has economically based views which create the logical explanation that these individuals are envious of the fact that a member of their community is getting a salary and is positioned and respected by the "others".

Brick Barrier Theory

One can view the process of Roma understanding, inclusion and acceptance as a destruction of barriers, a metaphoric wall, between the Roma communities and the government, the service providers and the mainstream population facilitated by health mediators. These various entities however do not share unanimous opinions on the marginalized communities both within the group and between groups mostly due to stereotyping, prejudice and lack of knowledge. Because of this internal division of opinion between a single entity a simple "removal" of barriers cannot be facilitated by the health mediator. A division of these metaphoric barrier walls has to be made as specific problems can be easily tackled individually. In order to track the process of Roma inclusion more easily each specific problem that has to be tackled can be regarded as a "brick" in the metaphorical wall. With each brick that the mediator succeeds to remove from the wall, the marginalized community comes one step closer to being integrated. However, the metaphorical wall does not only entail the removal of bricks – new bricks can easily be accumulated as well. As the mediator cannot necessarily satisfy the considerations from all of the different entities, he or she has to add and remove bricks accordingly. It is the job of the health mediator to create the most suitable conditions for the further destruction of the "metaphorical wall".

In this research there are various examples of such relations the most prominent of which is the case of the negative perception between a part of the mainstream community and the marginalized community. As both groups have extremely opposing views it is safe to assume that whatever the government and the mediator do, they will have a negative impact on one of the communities.

Perspectives:

Upon conducting this research from the perspective of the service providers the frustration and discomfort towards the health mediators briefly described in the previous chapter will be highlighted. Additionally, the service providers will provide accounts of positive interaction between themselves and the health mediators, however the level of comprehensiveness of the matter will not be as high as with the health mediators as the service provider, people who studied for ten years in order to practice their profession, are insubordinate towards the health mediators, people who attained their work positions after some two weeks of training. As mentioned in the text above another problem of conducting this research from this particular perspective is the fact that some service providers stereotype and have prejudice towards individuals form the marginalized community.

If this research was made from the perspective of the government, government officials would highlight the great successes of the health mediator's as they are part of the strategies and official policies of the government. They however would fail to admit that there are problems within this field of policy as the government believes that it is doing enough for the integration of the marginalized communities. Furthermore, the government would fail to recognize its unwillingness to empower the marginalized communities as individuals within the government will still have prejudices towards it. It is because of such shortcomings that the investigation of government officials is not advised in this subject area. Last but not least, the governmental perspective will also be able to elaborate on the opposition between the municipality and the central government that was briefly mentioned in the analysis portion of this research.

Conducting this research from the perspective of the mainstream population and form the perspective of the vulnerable and underserved minority the researcher would entail the collection of various, often opposing, opinions on the work of the health mediator. However because of the high level of variety in opinions, conducting such a research would require more time, more participants and a different methodology.

Conclusion:

While looking at health mediators as a state policy that is introduced with the main idea to assist access to health and social services for the vulnerable, marginalized and underserved strata of society, it is obvious that the more than 10 years of advocacy efforts, NGOs pressure and investments have guided to some very positive outcomes. The government evolution cannot be denied – mediators are recognized as official state policy, they are included in the list of professions, they have their own budget line in the state and municipality budgets. Moreover, there are some first signs for an inclusive approach in health services provision – health systems conduct screenings and provide mobile services for the non-insured and those in need in distant areas. All mediators are working in teams with service providers, and good service providers motivate clients/patients to actively seek health services.

Positivists in both vulnerable communities and mainstream population believe that mediators are doing good job. Mediators promote the change of opinion of the mainstream population through their actions, and there is a consensus that municipalities in general work well with mediators. On another hand health mediators are perceived by the marginalized not as simple representatives of the public administration, but as help, as savior. Mediators have their guild – the National Network of Health Mediators – a body that sets standards and criteria, requires quality performance and defends the interests of it members.

But one has to admit there is not only sugar in the cake – there are some bitter moments that need either fundamental change or slight improvement. For instance, there is a feeling in the community and even in many mediators that they are forgotten by the government. The government does not enhance proactive approaches - they continue to keep marginalized groups dependant on social benefits which deepen the dependency and the inability to search for solutions and better options and informed choices. The vicious circle still remains there. On top of this the marginalized community perceives that mediators are different from them – mainly because mediators are trained and employed by "outsiders".

While providing services, some GP's provide poor quality and base their attitude on stereotypes. GP feel observed critically by mediators, or are paranoid they observe them

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critically. This impedes the integration process and is not a good environment for teamwork and trust building.

When speaking about the mainstream population it has to be stated that for major part of them mediators are not known, and for those who know they are like the others, the marginalized. There is no desire for Roma integration as the general public's perception of them is that they are thieves, dirty and live on their back, an image with which the media has a great contribution with. When good things are obvious, there is still a passive aggressive appreciation for mediators – even if they perform well they are a rare exception that confirms the rule.

At the working place there is a temptation for government officials to use mediators for other "traditional" Roma jobs - mainly as cleaners, there is a double standard regarding salary and working conditions. Additionally, mediators are overloaded – newer and newer tasks are attributed to them, in horrendous working conditions.

What should be done? It is essential to continue with the integration efforts, mediators must receive the appraisal by the society and the better remuneration and working conditions they request. The institutions at central and local level shall invest in additional trainings, motivation and further development of the mediator as role model and good practice example. And last, but not least service providers and civil servants shall be trained as part of their educational formation on how to work in a multiethnic environment. This guides us to the necessity intercultural education to be part of the mandatory school curriculum – the change shall start from the younger generations that are free of prejudice and can easier understand that integration is not assimilation and that diversity shall be respected.

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Appendix

Bulgarian History of Mediation:

Bulgaria has developed three types of mediators in the last 13 years – education, labour and health mediators, the models for which have been taken by the Bulgarian government from the non-governmental sector (NGOs). In 1999 after consulting with NGOs and after piloting some models, the Bulgarian Ministry of Education elaborated a regulation which confirmed the employment status of education mediators. With the creation of that position however no major changes had appeared as the problem was not tackled directly – no proper integration foundations were made in order for the children coming from marginalized communities with Roma or Turkish roots to be able to have an equal start and equal opportunities removing properly the language barrier and striving for real, de facto, not only de jure desegregation in the school system(Health Mediator). The approach towards the health mediation was better strategized - in the beginning of 2001, the Foundation "Ethnic Minority Health Problems" started the first introduction of health mediators in the Roma district of Kjustendil. Later on in 2003 this concept was used by a consortium of NGOs led by Open Society foundation under the PHARE program - a project aiming to establish 15 GP practices in 15 municipalities with compact groups of underserved communities. Because of the great success of health mediators ever since their appearance, after systematic advocacy efforts of different stakeholders, the Bulgarian government adopted a 10 year strategy for the integration of marginalized communities, with special focus on Roma(Health Mediator). It is due to this strategy that the position of labour mediator was introduced in 2008. The implementation of culture mediators in Bulgaria still cannot be achieved as the rate at which the target group of immigrants comes into the country is still too low.

Health Mediator Relationship Overview:

Out of the three implemented groups of mediators the most arduous task belongs to the health mediators. This is because of the fact that they are combining health and social tasks, because they are working with the most severely marginalized communities in each of the Bulgarian municipalities, because they create the integration foundations for the other two types of mediators, because on a daily basis they have to fight against prejudice and xenophobia directed at them and the culture that they are trying to promote from members of the mainstream population, because they have to earn the trust of the members of the marginalized communities and because quite often there are herculean language barriers they must overcome(Health Mediator). A further grueling task that the health mediators must face is the maze of relationships with which the health mediator has to deal with on a regular basis. The first and most important relationship on the basis of which all other relationships revolve around is the one between the health mediator and the marginalized community. The mediator is an advocate and a persuader of the marginalized community and is also its member as the government considers this to be the best approach of community integration(Health Mediator). This also gives the mediator the unique perception of being able to experience events from the perspective of a member of the community and a figure employed by the government, an insight which can be very conflicting. An example of this conflict is seen in one of the fundamental roles a mediator has to fulfill – the provision of help that they have to give to the government with the implementation of governmental policies. Because of their close connection to the marginalized community, the mediators are sometimes better qualified at evaluating the success of these policies and can provide feedback to the government which as mentioned above can create tension between them and the government, more specifically their employers, authoritative representatives of public administration institutions from a central and local level - civil servants that work for the Ministry of health or regional health inspectors(Health Mediator). Another relationship that the health mediator has in regards to his job is that with the health service providers - MDs, GPs and nurses in the concrete case of this research. The relationship between these two entities is divided into two categories because of the diverse perspectives that the individual in the position of health mediator possesses - as a member of the marginalized

community, the mediator sees the service providers as prejudiced insufficient caregivers while from the position of health mediator the service providers are institutional figures in need of guidance and critical feedback(Health Mediator). Finally, the last important relationship that the health mediator has is between the health mediator as a member of the marginalized community and the mainstream population. Even if it is a one dimensional relationship, it is considered crucial for the integration of the marginalized community as both participants in the relationship harbor animosity towards the other. The Bulgarian government has acknowledged the high level of difficulty of the mediator's task. This is one of the main reasons that they are constantly increasing the number of health mediators working for the government while also increasing the number of municipalities involved in the process - in 2007 there were a mere 57 health mediators in 30 municipalities, at the beginning of 2012 however that number has grown to 109 health mediators in 57 municipalities and in 2013 the number is expected to be over 130 health mediators in more than 70 municipalities (Health Mediator).

Grand or Middle Range Theories:

In order to ensure the success of this project an adequate theoretical framework must be chosen. The first step that must be taken into consideration is the act of distinguishing the diversity of theories based on their application. Moreton separates this distinction into two categories – grand theories and middle range theories. The application of grand theories to this type of project work is considered in most cases to be unrewarding as there is a high level of abstractness and generality usually shown through the inability of the researcher to establish connections between the theory and the surrounding world and though the researcher's inability to identify a way of collecting serviceable data. Because of such inconsistencies with the use of grand theories, the use of middle range theories is advisable. Moreton defines middle range theory as "an intermediate to general theories of social systems which are too remote from particular classes of social behavior, organization and change to account for what is observed and to those detailed orderly descriptions of particulars that are not generalized at all" (Bryman: 2012 page 21). The basic idea behind this definition is the idea that this type of theory can create a link between the theory itself and the empirical, a link which can be verified by data because of the limited nature of applicability of the theory. It is however also important to note that each middle range theory is also abstract to some extent as not all of the claims that it makes can be supported by data. A good example of such a case in this project is the social learning theory as it claims that peer educators build up qualities of character throughout their job, an assumption that has provoked researcher's critique. The three theories used within this project are considered to be middle range theories as most of their claims are backed up by specific empirical data and as their connection to the topic is easily visible, the latter of which will be elaborated on in the theoretical part of this project (Bryman:2012 page 22).

Quantitative or Qualitative Data:

Based on the last two paragraphs above a logical decision can be made about the choice of a quantitative or qualitative research strategy. These contrasting strategies influence differently the process of collecting data – quantitative research employs the numerical collection of data and qualitative research utilizes the collection of verbal data with a strict focus on the meaning of the gathered information (Bryman: 2012 page 35). The two different types of research strategy also adopt different epistemological and ontological positions. Moreover, they also adopt a different theoretical approach. Regarding the accumulation of quantitative data, researchers usually adopt a deductive theoretical approach, a positivist epistemology and an objectivist ontology. Opposing this research strategy, the collection of qualitative data typically entails the adoption of an inductive theoretical approach, an interpretivist epistemology and a constructionist ontology (Bryman: 2012 page 36). The choice of theoretical approaches and ontological and epistemological positions in this project mimic the latter of the two distinctions. Furthermore, the choice of a quantitative approach would not have fit the project's goals as the different relationships that the figure of health mediator has are not numerically measured.

Type of Coding:

       As it has been shown several times above, the data analysis strategy of grounded theory entails the use of specific guidelines to many parts of the research. It is no surprise that this strategy also dictates the way that the actual process of data analysis has to be done - coding. This approach to data analysis breaks down the collected data into different distinguishable parts based on similarity, a process which further helps the creation of theory as the links between the different codes are easily visible (Bryman: 2012 page 710). Despite the researcher's lack of choice in the matter of analytical tool, he or she is faced with the task of determining the best form of coding for his or her research as three different coding practices exist - open coding, a form of coding which tries to fit the codes created by the process of data analysis into categories, axial coding, a type of coding which Bryman defines as "a set of procedures whereby data are put back together in new ways after open coding, by making connections between the categories" and selective coding, the category of coding which tries to create codes only revolving around one particular category (Bryman: 2012 page 569). The type of research from which this specific project will have the biggest merit is selective coding as only one category, the relationships that the health mediators has, is present in the current research.

Choice of Theoretical Framework:

A specific explanation that must be made before any further methodological argumentation is presented in this chapter is the choice of the theoretical framework. This concept varies significantly from the explanations of connectivity that will be given in the theoretical chapter of this project as these clarifications infer that a general overview of the researched subject will be made – the theories will be able to explore different important aspects of the researched subject. Moreover, the theories will also be able to intertwine between each other in order to create a deeper understanding of the problem at hand by developing newly formed connections between the specific aspects of the researched subject that each theory highlights. As the main idea behind this project was to investigate the various relationships with which the health mediator has to deal with, the scope of theories that would fit this research would be those that best summarize the wide range of various interactions that the figure of health mediator has. For example, the theory of social learning would present the links that a mediator creates from the aspect of peer educator. On the other hand, the theory of governmentality would present the connections that an individual has with the authorities on a national and municipal level. Both theories visibly deal with different types of relations and present unique perspectives on the matter which help the researcher create a distinctive overview of his researched subject. The utilization of those two specific theories also creates an inimitable prism through which the subject can be examined – the different relations that the mediators will have with specific figures from the government, more specifically looking at the government as the employer of the mediators and as a figure that needs to be educated by their peers. It is important to note that throughout the process of creating the research questions for this project, this theoretical multi-layering was taken into consideration, a trait on which will be shown in the analytical portion of this project.

Quality of Sources:

A further emphasis that has to be made regarding middle range theories is the importance of using quality sources and not background fact literature as to have a deep level of theoretical understanding. Reaching this high level of theoretical understanding can be done using the primary sources of the theory, however in most cases the theoretical saturation reached only presents the researcher with the opportunity to infer a connection between his research and the theory at hand. This connectivity assumption can be the instigator of critique which will decrease the research's influence. In order to maintain a high level of influence researchers search for secondary sources that are well connected with the primary source and easily relate themselves to the researcher's proposed research. There are several commonly used features that help determine the compatibility between source and research. Such features include but are not limited to the source's ability to be closely related to the researcher's problem as specific claims and concepts are taken from the primary theoretical source and are analyzed though a particular prism, the possibility that newer and more relevant argumentations and claims are presented then in the primary source, the use of a source scrutinizing a specific claim or concept from the primary theory as a measurement for determining the higher level of validity between opposing claims in other sources and the utilization of sources with an exceptionally in depth theoretical analysis of the primary source that ensure both applicability and theoretical saturation through various references, argumentations, critique refutals and provision of examples (Bryman: 2012 page 22). Naturally, as a high level of applicability is expected from the three theories, they fulfill some of the requirements listed above. For example, the social learning theory source used in this project analyses the connection that peer education has with health, a specific research which is more closely related to this project than the primary source. The text also provides numerous references to specific researches connected to the subject at hand, a beneficial attribute of the source as it further helps create a more fertile argumentation. There is also a high compatibility level in regards to the governmentality source as it not only supplies information concerning the theory – the source contains a thorough analysis of the primary source, includes a high level of theoretical critique which is refuted within the text itself and builds up on the primary theory. Last but not least, the sources concerning the broker-client-patron relationship theory also detain features of applicability mentioned above, as the sources used build up on the primary theory of patron-client relations to include broker-client relations. Additionally, the

sources juxtaposition the two different types of relationships within the theory and provide arguments for the alteration of one type of relation into the other.

First interview with health mediators

1.Please present yourself

    Name: Age:

    Location, district/neighborhood you work for, number of people you take care of:

    How long you work as health mediator:

2. How people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

3. According to you, why you are useful and needed to the service providers you work with? What did they learn from you?

4. How the "majority" looks at you? Who are you for the "mainstream", for the "others"?

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? Why?

Thank you for your time and efforts!

First interview with health mediators

1.Please present yourself

Name: Anife Hassan   Age: 40, female

Location, district/neighborhood you work for, number of people you take care of:

I work in the city of Dobrich, relatively big city in North-East Bulgaria – apr. 100 000 inhabitants. The total number of Roma community is 8 000= they are Muslim and they call themselves "millet". There is also a small number of Christian Roma. There are three Roma districts in Dobrich . The biggest one is "Izgrev" and is situated at the city borders. It is sort of general norm for Roma ghettos country –wide. The other two districts are not so segregated and communities there are respectively more integrated. In those two districts there are even some people with university degree. But in the most difficult one where I work people have no job and try to find various means for survival – they work different agricultural seasonal jobs, go abroad in order to support their families or try to be engaged as workers in the construction business. In "Izgrev" live apr. 5 000 Roma people. I am working predominantly in "Izgrev".

Why you work mainly there –

There is the greatest need for support, assistance and counseling. The municipality provided us with Primary care health center where health mediators work with general practitioners (GPs)= We, as a team, try to identify and solve the health and social problems of the minority group and find the right ways to solve them or at least move towards solving…

How long you work as health mediator:

6 years already, I was certified from the Medical college of Plovdiv. I am actually Vice-President of the National Network of Health mediators.

2. How people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

The values of the most vulnerable and capsulated are ranged in a different way. The priorities are different, not like in the non-Roma community.

In what sense?

On first hand it looks strange, but there are reasons for this different ranking – the difficult life conditions, poverty, the capsulated life builds other regulations and rules in this group. Finding financial means at any price no matter how are among the major priorities. Being rich, having food enough for the family, the possession of beautiful objects is also top priority.

Where is health in this ranking?

Unfortunately health and education are at the bottom. You are respected by your community if you are rich, and education and respectively health are not guiding to being rich in the perception of the community. At the same time we have to point attention at the so called "ghetto in the ghetto" I have in mind the poorest, the most vulnerable for which there is no perspective and who live day for day, thinking for today's meals at the most. The situation of these people is the most frightening –they are isolated and ignored from the other representatives of the community.

3. According to you, why you are useful and needed to the service providers you work with? What did they learn from you?

Major part of health service providers have already a stereotype about Roma, build up from an image of Roma in the media - thieves, criminals, traffickers. They speak with their circle of friends about Roma as dirty and people who do not pay taxes and live o the taxes and social programs of the majority. Our task is to change the attitudes, analyzing and showing the reasons why these people have such a lifestyle.

What about service providers?

In general doctors do not want Roma for clients, for patients – main reasons: "They are noisy, emotional, spontaneous, hand they have language barriers". And to a certain extend this is true. And here comes our role: to cope with emotions, to remove the language barrier… this is the way health specialists and marginalized community start to listen to each other and to understand each other. And our place is to incorporate between them – the community and service providers.

Do you have some successes, even baby steps towards success?

Yes, the specialists I work with are learning to be tolerant and patient. And they feel more comfortable and work better when they have health mediator working side by side with them.

4. How the "majority" looks at you? Who are you for the "mainstream", for the "others"?

For the minority we are people that provide services. Everyone who is in difficult situation searches friends. We are these friends - they trust us.

For the non-Roma it is a bit different. But as a whole people in Dobrich that know about us are with really positive attitude. On first hand they are impressed that there is a person from the community that is educated and works for the integration of the rest. The next thing, like automatic reaction is "Why we do not have health mediators?". I am having cases of people from other districts, from the mainstream population that also are seeking my assistance. I am working with them as well – I do not want to reject people that asked me for help and ethnicity is not relevant in the case.

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? Why?

1. To provide us with good and appropriate working place with decent working conditions

Do you mean payment with this?

Yes, but not only payment. Good working place near the community.

2. Support - with providing appropriate and up-to date information, and mainly with equal treatment and showing respect.

Do they show respect to you?

Yes, to me yes – I am vice president of our network, I study pedagogy, I've been to various conferences to present the profession, but I know what is going on in the country – and there are municipalities where mediators are used to clean the windows when needed…

What is the third thing?

3. I expect a good teamwork with government structures – only joint efforts give good results.

Thank you for your time and efforts!

First interview with health mediators

1.Please present yourself

Name: Boyanka Vragova   Age: 32, female

Location, district/neighborhood you work for, number of people you take care of:

Municipality of Panagurishte, small town in South Bulgaria, two Roma districts people are predominantly Christian Roma and speak Romani and Bulgarian. I am working also for seven villages, and the total number of Roma population is 2000 people.

How long do you work as health mediator:

In 2010 год I was certified from the Medical College in Plovdiv, I work ad mediator since 2011 and actually I am a student of economics in Plovdiv College for management.

How did you decide to continue to study while working?

 – I am the mother of two kids that are quickly growing up, I want to be a good role model and also my new profession inspired me to go further. My husband supports me – I will be the first with university degree in the family.

2. How do people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

There are people in the community open to discuss various topics –lifestyle related in general, not only health related. They are willing to listen to the advices of others. They are willing to take life in their hands. Those people are ready even to follow expert's advices. Unfortunately in my community major part of people are so depressed and do not see a perspective. So they live day for day. There is a third "variety" – capsulated people that do not want to listen to anyone and do not allow any access to them.

3. According to you, why are you useful and needed to the service providers you work with? What did they learn from you?

We support them and help them to reach the most vulnerable, difficult and capsulated.

4. How does the "majority" look at you? Who are you for the "mainstream", for the "others"?

There are people from the majority that also count on me for various services and search very often for my assistance and advice. There are people from the administration that rely on me and respect my efforts. But there are people that do not accept me.

How do you understand that? What do they say to you?

There is no need for them to say it – I can feel it from their behavior and attitude. It is good that they are only few.

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? And why?

To help us when we seek assistance

To show respect to us

To be a good practice example

What do you mean by that?

Mainly to not feel discrepancy between what they speak and how they act!

Thank you for your time and efforts!

First interview with health mediators

1.Please present yourself

Name: Semra Hussein   Age: 25, female

Location, district/neighborhood you work for, number of people you take care of:

I am working in Dobrich, 100 000 inhabitants city in North-east Bulgaria I am covering "Iglika" district, one of the three main Roma settlements in Dobrich.

How long do you work as health mediator:

I am one of the newest - from the last generation, working from 8 months, certified from the Medical university in Sofia in April 2012.

2. How do people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

People are desperate from their life-illiteracy, poverty and unemployment, it makes them feel "weak" and unwanted in society.

3. According to you, why are you useful and needed to the service providers you work with? What did they learn from you?

We actually are needed by them because a large percentage of the people in the community are illiterate. We in most cases are perceived as "translators" for them, we facilitate dialogue between the patient and the doctor because it is very difficult to communicate with someone who does not understand what you are saying to him.

4. How does the "majority" looks at you? Who are you for the "mainstream", for the "others"?

I am a person who helps the community, I have not had any negatives so far.

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? Why?

Mainly financial support,

The reduction of illiteracy

Easy access to health and social services

This will help the Roma community become "normal" people with decent human rights.

First interview with health mediators

1.Please present yourself

Name: Katia Alexandrova   Age: 27, female

Location, district/neighborhood you work for, number of people you take care of:

-I work in the town of Provadia, near Varna and the Black sea in North Bulgaria. I am working for the three Roma districts – southern, western and northern. I work for 2500 people in total.

How long do you work as a health mediator:

From April 2012 – I am from the last generation, certified form the Medical University in Sofia.

2. How do people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

Not all of them are careless; however some of the people I have to work with truly fit that description.

3. According to you, why are you useful and needed to the service providers you work with? What did they learn from you?

I think they have realized through me that they can reach the community and especially that they can change their way of living and thinking.

4. How does the "majority" looks at you? Who are you for the "mainstream", for the "others"?

They view me as "the girl who monitors vaccines, measures the blood pressure, helps to write applications for social support ... etc...etc.

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? Why?

1. More frequent meetings and exchange of experience with various institutions.

2 Sharing ideas for a healthy way of living for the community;

3 - Finally be securely funded.

What do you mean?

The budget to be assured and negotiations to not be needed at the end of every year.

First interview with health mediators

1.Please present yourself

Name: Jeman Hasan   Age: 48, male

Location, district/neighborhood you work for, number of people you take care of:

Varna, Asparuhovo district, 6000 Roma

How long do you work as a health mediator:

5 years 8 months, trained under the NGO pilot program, certified by the Ministry of Health.

2. How do people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

 - very differently depending on their age.

What do you mean?

The older generation perceived themselves as an important part of this society. They create opportunities for the younger generation. Appraisal towards a person is not given financially. It is rather depending on his/her participation within the life of the community and what they do for others. As we don't have much we deeply rely on moral valor.

And what about the younger generation?

The current generation is a consumerist one. None of them shows good values. They respect the person with the highest financial capital. It is important for them to wear branded new clothes, gold and to have a nice car. They believe that the world turns around them. I know that this view may sound pessimistic however those are the facts.

3. According to you, why are you useful and needed to the service providers you work with? What did they learn from you?

 I am needed by the service providers - at least this is what I believe because

1. I can explain the benefits of immunizations, preventive examinations

2 to search their patients and motivate them to go to the doctor when needed

3. I can improve the health culture of my own community

4. I can create a positive attitude towards health prophylaxis and encourage responsible health behavior in my own community

5. Most importantly I serve as a bridge between the community and the service providers as I can explain to both parties what the other one is saying and what values they share.

4. How does the "majority" looks at you? Who are you for the "mainstream", for the "others"?

They believe we are not like other Roma. We are an exception. The most annoying comment I often get is "You are not like the other Roma". I feel bad when I hear this sentence.

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? Why?

1.Information, Collaboration, Partnership

2.Additional trainings

3.Supporting activities for the Health mediator

Thank you for your time and efforts!

First interview with health mediators

1.Please present yourself

Name: Sabire Ramadan   Age: 45, female

Location, district/neighborhood you work for, number of people you take care of:

I work in the municipality of Septemvri in the south-west part of the country. The community is from Muslim Roma, speaking mainly Turkish. We are two with my colleague and we work for a small city and seven more villages.

How long do you work as health mediator:

More than 5 years, I graduated in the Medical college of Plovdiv.

2. How do people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

They are aware of their status and position, but due to the lack of education, vocational training, work opportunities they find it difficult to solve their problems. If they cannot solve their problems, their children inherit them. And vicious circle never ends.

3. According to you, why are you useful and needed to the service providers you work with? What did they learn from you?

 I facilitate communication between them and the ones in need of assistance. I provide them with information that the service provider is trying to give them – I disseminate information and communicate in a clear and accessible language. The service providers have learned from us that we will assist them and will follow their instructions. At the same time we communicate the message to the marginalized communities that this is for their own good. In this aspect we are very persuasive, of course based on the information about the health status of our clients on each health case.

4. How does the "majority" look at you? Who are you for the "mainstream", for the "others"?

They see me as the only person with the skills and knowledge to help the marginalized community. They see me not only as a municipal employee working for the Roma, but also an educated woman and as someone who is respected by the "others."

This is a heavy burden. How do you succeed to cope with such high expectations?

The fact that they see me as a person which is able through his conduct to change the relationship between the toe groups stimulates me - I like challenges, they mobilize me!

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5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? Why?

Good working conditions, budget allowing better coverage with health mediators, better payment - (we are really poorly paid).

What else is needed from the financial perspective?

For instance we need subsidies for travelling to the needed destinations - we cover 7 villages plus the city of Septemvri. There is a great need for an "emergency fund" as we need to help people in critical conditions.

Do you want something else?

Yes, I have one idea - In order for the mediators to work efficiently in each municipality, there must be a "head health mediator or senior health mediator" who has to supervise and help the newer mediators. He or she further has to help them with regards to institutional problems, to sanction them when it is needed and to conduct periodical exchange visits between newer mediators to let them exchange practices. It will be good if there is an appraisal form and the best performance to mean additional funds for the best health mediators.

Thank you for your time and efforts!

First interview with health mediators

1. Please present yourself

Name: Kalin Dikov   Age: 38, male

Location, district/neighborhood you work for, number of people you take care of:

Vratza municipality, North-West Bulgaria. I work with 2000 people, Christian Roma, speaking Romani and Bulgarian.

How long do you work as a health mediator:

4 years 2 months, I am certified by Plovdiv medical college

2. How do people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

In our community I first want to mention that people are in a very difficult social and economic situation. What do I mean by this? There is a high percentage of unemployed people. This is caused first by a lack of job opportunities, and then because of the low education and qualification of the community. Another important moment is the failure of the labor employment initiatives.

What do people do to overcome this?

Almost nothing - The people in our region are apathetic to everything that surrounds them. They trust no one. They perceive themselves as individuals that must combat the odds to earn money and provide nourishment for their family, and this is it. In other words they live day for day.

3. According to you, why are you useful and needed to the service providers you work with? What did they learn from you?

Yes we are very valuable for them and they mean it and acknowledge this. The priorities of my work are children. We, the health mediators are people who ease the access of our communities to health care. We track immunizations, annual check-up and everything else related to the health of our community. We further accompany, explain, instruct and fill out the necessary documents which are in favor of the health care professionals and community.

What have the service providers learned from health mediators?

Firstly they learned to tolerate the differences in the culture of the Roma ethnic group. An example of those differences is the large number of children in the family, the fact that when a Roma individual is admitted to a health institution his whole family has to come to visit him and stay for a while etc. Secondly, the attitudes of the service providers became more bearable, as they supply information about the applied procedures, the treatment and the manipulations and

they try to do it in an understandable manner. The service providers have become more tolerant to "the others".

4. How does the "majority" look at you? Who are you for the "mainstream", for the "others"?

I cannot answer this question as I don't like to evaluate myself. In one word – I am their main communication channel.

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? Why?

As it is well known mediators are field municipal employees in their respective community. This is a hard occupation that is not manageable by everyone as the health mediator must be ready to be close to the people, to hear their pain, requests, demands, to respond to a call for help and to solve problems.

I hope that health mediators will start receiving a better salary and have better working conditions. I want the government to obey the laws of our country. If mediators are civil servants they have to be treated as such.

And last but not least, I am expecting additional options for professional improvement for us.

Thank you for your time and efforts!

First interview with health mediators

1.Please present yourself

     Name: Dinitrinka Borissova   Age: 27, female

     Location, district/neighborhood you work for, number of people you take care of:

     The village of Medkovets, Montana region (North West Bulgaria). I am working for the Roma community in the district Zheraviza. In Zheraviza live 500 Roma, and 360 more are disseminated in the village, so I serve 870 people.

     There are four more villages I work for with a total number of Roma population of 1569 inhabitants.

     How long do you work as a health mediator:

     I was trained in 2007 under a project funded by the MATRA program of the Dutch foreign ministry implemented by Bulgarian NGOs. I work as a health mediator since 2008, five years already. Actually I am a second year student in the medical college in Sofia - I am following my dream to become a nurse.

2. How do people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

People in the community have different perceptions and different problems, as in other communities. There are however some common characteristics – extremely high unemployment rate in Nord-West Bulgaria, low income, lack of normal living conditions etc. A Major part of the population does not think about their life realization – they lack self-esteem and hope. Unemployment is the major issues. Thus the main goal of people within the community is survival.

What is coming out of this?

What comes is the belief of these people that they are poor and respectively forgotten from everyone else. This is the way they perceive themselves – the forgotten. It is good that a considerable percent of adults understands that education would change their lives if it is happening in the appropriate time. In the community everything is like in a vicious circle, many try to break the cycle, few succeed, and some even do not realize their life is entirely going in a vicious circle.

Do they try to take some measures?

Well, people still expect someone to come and save them. On one hand it is logical, but on another this means you do not fight for what you want, you have a passive approach to life and in the best case expect someone to fight for you.

What are people's priorities?

The main ones are family and love, everything else is arranged by God and Destiny. And such a belief was supported by the state policy. For years people live on social benefits – small - modest, but still something. This creates dependency and strengthens the belief that this is the only way to survive - only with social benefits. People must not take care of their life – the state will take care.The state is not proposing other proactive options. And now in the period of crisis there are no social assistance funds for everyone. The social system is shrinking. People try to find jobs, but when you are not educated it is not realistic.

What should be done strategically?

There is a need…not for more than ten years there is a need to stop school dropouts, to organize educational opportunities for adults on the lifelong learning principle. And last but not least, to create working opportunities. This is real integration and good social policy. And unfortunately it is lacking.

3. According to you, why are you useful and needed to the service providers you work with? What did they learn from you?

I am needed due to the specific tasks I am accomplishing. The mediation between health services providers and vulnerable community is very important for both sides. I am needed, because I know where the children who do not visit their GPs are. I can be persuasive and motivate people to   demand health services because I know the community. I say to people that they have rights but also obligations and responsibilities and they believe me. Health specialists earned how to work with people using me as their voice and as good model and example. I hope this will guide to changing the way of thinking of my community.

4. How does the "majority" looks at you? Who are you for the "mainstream", for the "others"?

They find me …different form their standard idea about Roma. At the same time people from the mainstream population that know me said that I am a dreamer, because I believe in things they do not believe in. защото вярвам в неща, в които те не вярват.

Such as?

Good end – integration, better education…such dream things.

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? Why?

1.Normal, equal working conditions and contracts for work.

What do you mean?

I will give you an example – I am working in an office where there is no heating, and everyone else is working in offices with heating. I dream for a time when they will not ask you to go on not paid leave for one month because "the municipality is not having enough funds" but the others go to work…

2. Support on local level

3. We need a body that will support and monitor our work and go for site visits. I know the national network does it, but there is a need for external monitoring.

Thank you for your time and efforts!

First interview with health mediators

1.Please present yourself

Name: Sema Asenova   Age: 40, female

Location, district/neighborhood you work for, number of people you take care of:

Haskovo, City in South Bulgaria near the Turkish border, Roma are Muslim, they speak Turkish and their number is up to 15 000 (with seasonal migration it varies to 10 000 when people go mainly to Greece and Spain for seasonal work)

How long do you work as a health mediator:

I work as mediator since 2007. From one year I am the first mediator that works extra in the hospital where my services are badly needed, especially in the maternity and pediatrics unit.

2. How do people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

They deny that they are Roma and prefer to identify themselves as Turkish - their language is Turkish, their religion is Muslim and they say "we are Turkish" because Turkish people have better reputation and are better accepted. But Turkish people say "You are not from us – you are Roma" And people from the so called "millet" get angry when they are called Roma. They feel offended to be called "Roma".

And how do you want to be called or seen?

For me it doesn't matter. The essential is that these people are poor and in need for help and assistance.

3. According to you, why are you useful and needed to the service providers you work with? What did they learn from you?

We contribute for a better dialogue between service providers and clients. We work on the field, we go from door-to-door, we help identifying children for immunizations, and we stimulate their parents to do the screenings and other exams with mobile units that are free of charge and their option for better health.

What is your role in health messages dissemination?

We overcome language barriers, when the population cannot communicate with doctors and nurses. We assist health specialists for organizing and conducting informational and educational sessions. People understood that with us, it works easier for both sides.

4. How does the "majority" looks at you? Who are you for the "mainstream" and for the "others"?

I am one of "them". But at the same time I help with problem solving and conflict resolution, this makes me different. In the beginning it is strange for the newcomers; later on they really appreciate what I am doing.

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? And why?

1. Training of more health mediators for a better coverage of the communities in need – there are still municipalities that need such service.

2. Development of health mediators positions in the big hospitals – based on my experience in Haskovo hospital, it is badly needed!

3. Better working conditions, better financial stimulation, moral support and appraisal of the job.

Thank you for your time and efforts!

First interview with health mediators

1.Please present yourself

      Name: Peter Zvetanov   Age: 37, male

      Location, district/neighborhood you work for, number of people you take care of:

From 2005 to 2012 I was working as a health mediator in Vulchedrum. Since June 2012 I am working in a new location – in Montana municipality as a health mediator. We are two mediators in Montana \town in North-west Bulgaria) I am working in one of the districts - "Kosharnik" - and my colleague in the other one – "Ogosta". As in many other locations Kosharnik is at the city borders. Again according to the tradition, the other district is near the river and the railway station. The number of Roma in Kosharnik is 3000. This is our main target group. We work predominantly with hard to reach population in order to increase their health culture and to include them in prevention programs. The community speaks only Bulgarian - they are from the so called "tzutzumani".

      How long do you work as a health mediator:

I work as a health mediator since the end of 2005. I was trained under an NGO project funded by the Dutch government. I am President of the National Network of Health Mediators, I am volunteering a lot for the organization. But sometimes I feel the consequences of a burnout syndrome and feel really tired.

2. How do people from the community you work for perceive themselves? In other terms what is their attitude towards themselves?

It is individual.

Can you try to summarize it?

OK. There are two kinds of people. Some of them expect always and for everything to receive help and to be passive, just "users". They think it is part of the obligations of the society to offer them care services, aid etc. The other group consists of more proactive people that rely on their own forces. And here we come to the most popular group – of those who do not care and live day for day…

3. According to you, why are you useful and needed to the service providers you work with? What did they learn from you?

We help them to fulfill their duties and to have a better performance. They would be impeded without us. I dare to believe that we are the ones that teach them to respect the opinion and the culture of the vulnerable community. We help them to embrace diversity.

4. How does the "majority" looks at you? Who are you for the "mainstream" and for the "others"?

On one hand I am Roma, on the other hand I am a health mediator and part of the public administration. So – this means it is complicated to form an opinion. A Major part of the people considers me as the good catalyst of change.

5. What are the three most relevant things that governmental institutions at central level must do in order to facilitate the work of health mediators? Why?

Gratitude – simple human gratitude

Stimulation of our efforts – Simple financial stimulation

Development of the health mediators' concept

This is not simple - what you mean by that?

It is very hard to identify representatives of the Roma community with high educational level that are willing to invest in the community and to do field work, Such people, once identified, must be sustained – so it is very important to invest in their capacity building.

Thank you for your time and efforts!

Second interview with health mediators

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

3. Is the "majority" having different attitudes towards you and towards the underserved community you work provide services to? Why?

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

5. What is the attitude of the community you work with towards you? How they perceive you?

Thank you for your time and efforts!

Second interview with health mediators

Anife Hassan

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

Health is at the bottom of priorities, health is question of good luck, not of care. It is just a little bit more relevant than the last one – education.

And prevention?

Thus prevention is not having place in the priorities list. This is one of our goals – to succeed to persuade people that prevention works and is relevant.

How you do it?

For instance since we started the screenings against cervical cancer with the mobile units that include people without health insurance, people started to pay attention on what we say, and started to pay attention at their own health.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

Yes! Health specialists that cannot be tolerant towards differences are using the ignorance of the vulnerable communities and provide poor quality services – during examinations, while referring them to other service providers, trying to take money for people with health insurance (they do the latter not only to my community, but to all. They see us as MENACE. We know the rights of the clients and the responsibilities of service providers. We can empower clients and make them stand for their rights. Sooo, we are dangerous.

3. Is the "majority" having different attitudes towards you and towards the underserved community you work provide services to? Why?

The so called majority is not homogenous. There are different people with different beliefs. There are people that are not happy with their lives and they have to find a general reason for this, or plenty of reasons and these reasons must come from outside. They want to be sure it is not their own fault, and they direct all the aggression to the "Roma problem".

What is their thesis?

"Everything is for Roma, all services and programs focus on Roma, we suffer because of them, they have to be isolated, they have to be terminated"… this kind of attitude.

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

1. The municipality – provides working lace and working conditions

2. Social services department – health and social problems are very often interrelated –and while working on particular cases we work for both – health and social issues.

3. GPs – General practitioners – our main ally, the person working on primary health care.

5. What is the attitude of the community you work with towards you? How they perceive you?

It depends of the situation. Sometimes they expect from us the impossible. They expect the health mediator to fix their life in all aspects. And we are fair and discourage such expectations. Then other reactions come – and we are insulted, humiliated, and kicked out of their houses.

Are there good moments as well?

Yes, and thanks god they are the major part of moments. When we succeeded to held, we read gratitude in people's eyes. And hope – something very precious. But let me go back to the bitter side – there is third types of reaction – there are people from the community that envy us - jut because we have a job, a salary, no matter how modest it is. As I said – it is very relevant to earn money.

Thank you for your time and efforts!

Second interview with health mediators

Boyanka Vragova

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

Very different – there are people that are happy that we exist. Nobody is unhappy, but unfortunately the majority is indifferent. – They do not pay attention to the fact that we exist and work for the community.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? And Why?

No, all of them know already about me and my job description and they started spontaneously to seek my support. I cannot complain.

–how can you explain this relatively quick success?

Maybe because we are a small town and we all live more or less integrated we have this feeling of solidarity…

3. Is the "majority" having different attitudes towards you and towards the underserved community you work provide services to? Why?

Yes. I can say when I started several told me "I cannot figure out how you are going to help Roma and how you will influence the integration process – it is hard, it is complicated". I think a major part of them now say "It is good that there are trained people like you" or "you are a good role model".

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

Center for social support "Zora"

Local commission for fight against criminal acts of adults and minors – I am a member of this voluntary interdisciplinary body at municipality level.

Department for child support

What are your joint actions with them?

We work jointly on various case studies and we have success.

5. What is the attitude of the community you work with towards you? How do they perceive you?

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In the beginning people were thinking (and hoping) that I will give them money. I explained little by little what the role is for the health mediator and they were…disappointed! Some said "So, you cannot help us, there is nothing you can help us with?" Now they are happy I am there, they are grateful I help!

Thank you for your time and efforts!

Second interview with health mediators

Semra Hussein

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

Because we cannot afford to pay health insurance, health prevention is considered to be something unreachable.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

In our city, the GP work with, has no such worries. She believes we are a great help.

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3. Is the "majority" having different attitudes towards you and towards the underserved community you work and provide services to? Why?

It is different because I am literate, educated. I "do not look like them, do not behave like "them".

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

Municipality in Dobrich

Regional Health Inspection

Social support services

The main problems of Roma are the health and social care. We refer to them in case of problems.

5. What is the attitude of the community you work with towards you? How do they perceive you?

They see me as a "savior", as the person they can rely on and it is at the same time "one of them."

Thank you for your time and efforts!

Second interview with health mediators

Katia Alexandrova

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

 The majority of the people are not very aware of health prevention and their health status due to a lack of information and lack of resources in order to take care of their health.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

The majority of them were worried in the beginning, but now only very few of them! Perhaps because they did not know that I would be helpful and were afraid I will "control" them.

3. Is the "majority" having different attitudes towards you and towards the underserved community you work provide services to? Why?

Not quite. I believe a person who is human oriented and understanding will see my desire to work, regardless from which group they come from.

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

1.Center for Social support and Social assistance services

2. Regional Health inspections

3. General practitioners

 They conduct jointly organized examinations, vaccinations, information and support for team work in our various campaigns.

5. What is the attitude of the community you work with towards you? How do they perceive you?

They expect me to help them. Not all look at me in this light because some are full of anger or envy me. However I understand it is not possible that everyone like me.

Thank you for your time and efforts!

Second interview with health mediators

Jeman Hassan

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

The attitude towards health compared to other districts in Varna is better. Here Roma are slightly better financially and have good hygiene habits. Asparuhovo is known as "the district of the pimps"

So, no major difficulties?

Just the opposite – if someone of the family gets sick, all the clan goes with him to the GP or to the hospital. GPs prefer me to be with the patient in order to be sure things will go smoothly. The topic of health prevention is difficult to discuss with the community as it is not a priority.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

They believe that because we are part of the municipality administration, we can or even have to act as a supervisory body. And people do not like to be supervised.

This year with the campaign for cervical cancer prevention we broke the ice between GPs and mediators - GPs saw how people follow our instructions and make screenings a really strategic event.

3. Is the "majority" having different attitudes towards you and towards the underserved community you work for and provide services to? Why?

Yes their attitude towards me is different as my attitude towards them also differs.

Why?

My behavior is depending mainly on their behavior towards me and the empathy and esteem they show to the community. They see me as different and on one hand this is reinforcing for them. On another, or I shall say for other people, it is embarrassing to have such "emancipated" Roma. All is based on stereotypes and prejudice.

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

Regional Health Inspection - informational materials, Voluntary counseling and testing (VCT) for HIV, Wasserman, Hepatitis B and C, Chlamydia, the immunization of children without a GP and the facilitation of a mobile health office.

TB dispenser – they organize so called open door days and assure tuberculosis exams and treatment for free for people without health insurance.

Municipality – they help us, we help them

5. What is the attitude of the community you work with towards you? How do they perceive you?

As a municipality servant that is obligated to do anything for them. I have one main plus – I speak the language, so I must do everything, going far from the health "borders".

Thank you for your time and efforts!

Second interview with health mediators

Sabire Ramadan

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

They are irresponsible for their own health and responsible for their children's health.

How do you explain this phenomenon?

Family and children are the main priority in the scale of values. So they neglect their own wellbeing and prioritize the wellbeing of their children. However, now in some locations people are looking for health prevention information. And there are still some that do not want to hear about prevention or health care as a whole.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

Service providers do not want us to witness something that they must not do, see or hear. In many of the cases I am expected to pretend not to hear or see either.

3. Is the "majority" having different attitudes towards you and towards the underserved community you work provides services to? Why?

For the mainstream community, I am integrated. At the same time however I am not part of their community. They see me as an irreplaceable municipal employee for a big part of the illiterate, uneducated and living "on the back of the government and on our back".

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

Municipality

Social services unit

GPs and other service providers

5. What is the attitude of the community you work with towards you? How do they perceive you?

They see me as a person who will help them to solve their problems - any problem! I am valuable to them. Also respected and I even dare say, loved.

Thank you for your time and efforts!

Second interview with health mediators

Kalin Dikov

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

I will have to be honest and say that since the introduction of the position of health mediators the Roma community cares more about its health and the number of individuals that undergo prophylaxis has also increased. I believe that here I should mention the prophylaxis done by our local community. It included gynecological exam, Pap smear (test for cervical cancer prevention), Tb prophylaxis etc. With young people it is very difficult.

Do you know why it is so difficult with youngsters?

It is difficult simply because young members of the Roma community do not trust the service providers. With my help this problem has started to go away as I escorted them, explained their diagnoses, procedures and treatment. I have been a health mediator since 2008 and I would like to share some of the things that I have noticed. In the first six months I've noticed that many children (in Bulgaria all persons under 18 are insured by the government) have no GP. So I started to motivate the parents to identify a GP for their kids and to respect the immunization calendar.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

No, and I don't believe that they should be afraid of anything.

3. Is the "majority" having different attitudes towards you and towards the underserved community you work provide services to? Why?

Of course it is different. Our society does not tolerate the different people. We are not prepared and ready to be tolerant. This is a fact which is not hidden in any way. There is a stigma, the seal has been put. I believe that people must be evaluated by his or her own professional characteristics. I divide people into two categories – good and bad. In order for my Roma community to be accepted by the society we, the Roma must be willing to work, must have a good hygiene and must be honest.

And what about the majority?

It is valid for them as well, but the essential is to stop thinking with prejudices based on stereotypes.

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

- the municipality Hospital

- Local social support agency

- Municipal Labor directorate

5. What is the attitude of the community you work with towards you? How they perceive you?

They think I am their savior. They perceive me as a part of their family, as an respected member of the community.

Thank you for your time and efforts!

Second interview with health mediators

Dimitrinka Borissova

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

A Major part of the people does not have access to health care. We are lucky enough that our local GP works with non-insured people, for free or with the uncertain hope to get paid…one day. Five years ago people literally did not know what health prevention means. After five years of intensive work I am proud: people have the wish to participate in screening programs and to use each opportunity for preventing their own health, to participate in health educational sessions.

How was it before?

In the beginning I had great difficulties to get people for a screening or informational session, or whatever. I was persuading them in the streets, in their little gardens, and I had to use all my communicative skills over and over again. Now people have a different approach and this is good. People go voluntarily to discuss health related issues and for such a small isolated villages like ours it is a big success. Health is still at the bottom of priorities, but there is an interest shown towards prevention – it may be a baby step, but it is a step. The thing they start thinking of very slowly and with great difficulties is contraception and family planning in general. I have to work with one woman for months in order to provide her with modern and informed choices and the woman to have courage enough to request an IUD insertion.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

I do not have such observations. They feel uncomfortable when they say unconsciously something offensive on Roma and I am there. This is part of the social norms, of the culture sometimes there are just common expressions, but they are offensive – "dirty like Roma", "You are lying like Roma" etc. When they say the expression and realize I am there, people feel uncomfortable.

How do you feel when that happens?

I know it is part of the language, but this is not making it less offensive, as you know. The thinking is "when you are looking and acting like us, this automatically makes you a non-Roma, or at least, not a real Roma". And there is something else – people are embarrassed of how they will be accepted in the Roma community – they are simply afraid!

3. Is the "majority" having different attitudes towards you and towards the underserved community you work provide services to? Why?

Yes, the attitude is different! I am sick and tired from the universal explanation "you are not like the others" or "sorry, it is not addressed to you, it is not valid for you"

What do you say to them?

I am saying that I am one of them, of Roma. I had the chance to have great parents, who support me and want me to study. I am a single mother and while I am busy my parents look after my son who is in second grade. I am a student for one year and now and I combat other obstacles. But as a general conclusion I can say that all my colleagues and partners respect me and my quality of work.

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

1.Municipality – provides my working place

2. GPs and Regional Health Inspection – my main duties are connected with them

3.social welfare unit – it helps for the solving of many problematic cases

5. What is the attitude of the community you work with towards you? How do they perceive you?

They see in me as the person that can help for everything. Sometimes they expect miracles from me. They believe in me and know that I am doing my best to not disappoint them. This trust building is my best achievement.

Generally speaking what is it in one sentence?

I am well accepted from both the vulnerable community and the service providers. I am a role model for my community. Moreover, I am a good example for all single mothers that raise their kids on their own!

Thank you for your time and efforts!

Second interview with health mediators

Sema Asenova

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

Some people are more caring for their health and go to the doctor. Others do not pay attention at their own health – just like in other communities. The main difference is that the percentage of those who do not care about their health is much higher. The main unsolved problem is that a major part of the community is out of the Health insurance system - and these people, and they are almost all; go to the doctor only in case of severe diseases, emergency situations, operations etc. In order to afford health care, the community fundraises and collects money for the manipulation. It is very, very, hard and with no strategic approach towards the issues.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

They are embarrassed to a certain extent – the mediator is a figure, competent enough to identify gaps in service provision. They feel uncomfortable because the mediator can send a critical note to supervisors create problems.

Does that happen often?

No, as a mediator I think on the first hand that we have to act as a team and even if there are problems we have to try to speak about it first and try to overcome obstacles. It works - slowly but surely!

3. Is the "majority" having different attitudes towards you and towards the underserved community you work with and provide services to? Why?

Yes, they make a difference. They say "you are not like the rest" and this is offensive even if people say it with very good intentions. At the same time the so called majority is relaxed that there is someone that takes care and tries to make things happen. And they will not do it on their own…

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

1 . Regional Health inspections

2. GPs and pediatricians, hospital authorities

3. Municipality

5. What is the attitude of the community you work with towards you? How do they perceive you?

They feel better.

In what sense?

They feel better understood and the beginning of trust building is set.

Thank you for your time and efforts!

Second interview with health mediators

Peter Zvetanov

1. What is the attitude of the vulnerable communities you serve towards health and health prevention?

Well it is again different but the underestimation and lack of serious approach prevail. Health is given by God and by destiny – and there are not many things to do about it – this is what the community believes. Such behavior of course is connected with the poor living conditions.

2. Is there something that makes service providers feel uncomfortable/endangered/ in competition while working with you? Why?

No, I do not think so. There are isolated cases in which service providers think health mediators can cause troubles – if they report mistakes or missing actions. But I believe that only the irresponsible health services providers feel embarrassed by the presence of the Mediators – the others are happy to have allies and partners such as the mediators.

3. Is the "majority" having different attitudes towards you and towards the underserved community you work provides services to? Why?

Well the majority does not want to admit that among Roma there are honest educated and working individuals. If they accept such a statement this will mean that all the prejudices are fake and their reason for pride is also fake. It is very difficult to get rid of stereotype thinking.

Do you face other types of attitude?

Yes! I was about to say – there are people that perceive us as missionaries. They respect us and pay tribute to our efforts.

4. What are the three most relevant institutions/partners at municipality level that support and facilitate the most the work of health mediators? Why?

Municipality – workplace provision, gives us identity;

Regional Health Inspections – we have common goals and prevention programs

Local NGOs – it is a very important supporter at local level.

5. What is the attitude of the community you work with towards you? How do they perceive you?

We are there to respond to everything. People think that we are in the municipality and thus we can solve all their problems – with housing, with social assistance, with unemployment, with finances…These expectations are very unrealistic and we try to explain what is in our mandate.

The first reaction is disappointment. After a while things start to go more smoothly and we even come to the moment when the community is grateful for our efforts.

Thank you for your time and efforts!

Consent form

I, the undersigned Anife Hassan, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Анифе Хасан

Consent form

I, the undersigned Boyanka Vragova, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Боянка Врагова

Consent form

I, the undersigned Dimitrinka Borissova, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Димитринка Борисова

Consent form

I, the undersigned Jeman Hassan, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Жеман Хасан

Consent form

I, the undersigned Kalin Diko, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Калин Диков

Consent form

I, the undersigned Katia A;exandrova, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Катя Александрова

Consent form

I, the undersigned Peter Zvetanov, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Петър Цветанов

Consent form

I, the undersigned Sabire Ramadan, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Сабире Рамадан

Consent form

I, the undersigned Sema Alexandrova, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Сема Александрова

Consent form

I, the undersigned Semra Hussein, officially confirm that I allow the data provided by myself to be used in research with regards to health mediation in Bulgaria.

Sincerely yours:

Семра Хюсеин