Attitudes and Praxis of Traditional Forms of Health Care in a Post-Communist Romanian Romani Community

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Abstract:

Prior to the communist period most Romanian Romani communities depended mainly on traditional healing methods as a primary source of health care. After its ascension to power, the Romanian communist government introduced a universal, Semashko-style health care system. The implementation of these requirements dramatically disrupted the traditional health care patterns for Romani communities for over 40 years. Since the collapse of communism these constraints have been lifted and social health insurance (SHI) has been adopted in Romania. Insurance coverage is based on formal participation in the labour market. It is well established that the Roma have fared poorly during the transition to liberal democracy and have suffered particularly in the labour market. Consequently, many Roma are unable to qualify for SHI and remain uninsured and in poverty. Understood within this context, it could be expected that a resurgence in and reclamation of traditional healing methods in the Romani community might be found. This paper draws upon qualitative data from Romani groups in Bucharest and explores the practice, perceptions, and attitudes toward traditional health care in a socially liberalized and increasingly market-driven Romania.

Introduction

Prior to Romania's communist era, Romanian Roma primarily relied upon their traditional medical practices and beliefs, as they were a largely unintegrated, excluded, and nomadic population. However, after its ascension to power, the communist government implemented stringent modernizing health laws which were based upon citizenship that mandated adherence for all Romanians. At the same time, the communist government actively sought to restrict and repress expressions of ethno-religious affiliation and practices, deconstructing traditional kinship networks and forcibly assimilating Roma (and other ethnic groups). However, the collapse of communism, and the commensurate democratic and neo-liberal transformations, has dramatically changed Romanian society. Socially, Romania has experienced increased liberalizations which permit heretofore restricted expressions ethno-religious identity to be reclaimed. Alongside that, Romania has embraced marketization, which has resulted in limited access to health care for the poor and vulnerable. Situated at the intersection of these social liberalizations and marketization are the Roma. On the one hand, the social liberalizations have lifted prohibitions against practicing traditional medicine – in a sense, allowing a "pull" back to traditional medicine. And on the other hand, the marketization of health care has "pushed" poor and vulnerable groups, like the Roma, away from equitable access to medical care.

This paper seeks to analyse these "push" and "pull" factors to explore to what extent there is a resurgence or reclamation of traditional medical practices and beliefs in Romanian Romani communities today.[1] Towards that end, first a discussion of what is meant by "traditional Romani medical practices and beliefs" is presented to frame further analysis. The next section examines how the dominant health care models have changed from the pre-communist period through the present. Third, findings from 43 in-depth interviews with Romani patients in Bucharest are presented to help understand how traditional health care

beliefs and practices are viewed and practiced today. Finally, a discussion and analysis of the significance of the interview findings is presented.

It is hoped that this paper will, first, generally add to our knowledge base about the Roma – an understudied population. Also, this research seeks to help to fill in important gaps about the health needs of the Roma today. The paper should find resonance with a diverse audience given the scope of the research – scholars of health care reform, Romani specialists, cultural anthropologists and students of Romanian communism.

Traditional Romani practices and attitudes toward health and care

For the majority of their history in Romania, the Roma have lived on the margins of Romanian society. Unlike some ethnic groups in Romania, historically the Roma have successfully – partially by choice and partially because of external pressures – maintained an identity which was largely separate from that of the ethnic majority. Traditional Romani language, lifestyle, and culture are distinct and are informed by their origins in the Indian sub-continent and their historical nomadism. Like most ethnic groups, the Roma have historically maintained their own culture surrounding their understanding of health and health care. Defining "culture" is a highly contested issue. Various scholars have proffered definitions (e.g., Kroeber and Kluckhohn; Geertz; Levi-Strauss; Douglas, inter alia), and proponents and detractors remain in all camps. However Swidler (1986), leading on from Hannerz (1969), provides a salient definition of "culture" apropos to this research. Swidler suggests that culture can be defined as "symbolic vehicles of meaning, including beliefs, ritual practices, art forms, and ceremonies, as well as informal cultural practices such as language, gossip, stories and rituals of daily life" (Swidler 1986: 273).

The kinetic nature of culture allows for the fact that Romani culture has been shaped by historical nomadism – adopting and adapting traits and beliefs of various groups. For example, most Romani groups have adopted the dominant religion of whichever country in which they reside, e.g., Catholicism in Croatia; Orthodoxy in Romania; Islam in Turkey, etc. (Barany 2002). Indeed, Roma are a highly diverse ethnic group, and there are numerous clans of Roma throughout the world – Ursari, Vlach, Kalderash, and others. Each clan possesses characteristics which distinguish them from other Romani groups, yet there are unifying characteristics as well. Just as the Roma have adapted certain customs from other groups, Romani cultural diffusion has also influenced the dominant cultural majority. As a result of this, Romanian and Romani cultures share some common health related folk practices such as reliance upon home remedies – drinking teas, eating certain soups and herbs, etc. Despite some cultural overlap, observers have noted that there are particular health-related beliefs and practices which are more pronounced and apparent within Romani groups specifically, and these beliefs and practices are shared and common throughout Romani groups, irrespective of specific clan affiliation. These distinctive practices and beliefs are, for the purposes of this research, referred to as "traditional Romani beliefs and practices."

First, scholars have noted that Romani groups ascribe ill-health to exogenous factors such as bad luck, curses, or spiritual possessions. As a result many methods of healing are respectively, supernatural, magical or spiritual in nature and lacking a bio-medical basis (Tomova 1995; Petek, Rotar Pavlic et al. 2006; Sandu 2009; Mladovsky 2007; Clayton 2002). For example, some Romani groups believe that clipping the hair and fingernails of the ill person and throwing them into a river can ward off illness, others drink a glass of water that has been held up to the moonlight. Still other Romani communities believe that decorating one's home with quartz crystals and horseshoes can stave off headaches (Kemp 1997). Despite the variations in specific practices, there is a unifying belief that spiritual or

magical factors influence health (van Hausen 1992). Much traditional Romani healing also relies on alchemy and the creation of potions, usually concocted from herbs (Clayton 2002).

Second, remedies are often administered by an older woman, a healer, or the female head of the household. Indeed, traditionally it is women who are chiefly responsible for the health and maintenance of the family; men are rarely involved in the health decisions for children and other dependents (Clayton 2002; EUMC 2003; Smith 1997). Indeed, within Romani communities strict sex segregation in matters of health is often upheld – men traditionally do not participate in or accompany their partners in any obstetric or gynaecological procedure, nor are they present for the delivery of the baby, mainly because it involves *marime,* impure or dirty parts of the body (Vivian and Dundes 2004).

Third, Roma distinguish between the *Roma* and the *gadje* (singular is *gadjo*). Gadje is often translated as "outsider" and it refers to all non-Roma peoples. According to traditional Romani beliefs, the gadje world is polluted and harmful to the Roma. Therefore care is taken to avoid most contact with gadje not only in situations of health care, but also in life more generally. Some observers have, for example, noted that when Roma must interact with gadje they may refuse to touch the gadjo or any of the gadjo's belongings because of fear of contamination (Sutherland 1992). Strict beliefs about purity and contamination have historically mediated interactions between Roma and gadje (Sutherland 1992; Liegeois 1994; Smith 1997; Guy 2001; Hancock 2002; Vivian and Dundes 2004). As there are very few physicians of Romani descent in Romania, neither currently nor historically, formal health care has been almost always administered by non-Roma. It has been suggested that because of this belief in the contaminating qualities of gadje, Roma may be less likely or unwilling to seek formal medical care because of concern over purity (Liegeois 1994; Ringold, Orenstein et al. 2005; Rambouskova, Dlouhy et al. 2009), thus reinforcing dependence upon and belief in other methods of healing.

Fourth, traditional Romani customs maintain strict proscriptions about female modesty and purity. These controls on purity extend to both gadje men as well as Romani men; however, given the contaminating nature of gadje generally, interactions with male gadje are considered the most compromising. Some observers have proposed that Romani women may not seek medical care for fear of having to expose themselves to or being touched by a gadjo male doctor (Smith 1997; EUMC 2003). This type of interaction can be perceived as 'polluting', and may also bring shame to the family of the female patient. In extreme cases, the polluting effect of being examined by a male gadjo may make a Romani women ineligible for marriage (Weyrauch 1997).

Again, as stated earlier, remember that the above-mentioned cultural beliefs are not purported to be an exhaustive and definitive list. That task would be almost impossible given the diversity of Romani groups throughout the world. However these particular beliefs were highlighted because it is generally acknowledged that these are broad, overarching beliefs shared by most Romani groups. For example some scholars have pointed out, separation from the gadje is one of the most enduring Romani cultural values, across all Romani groups, irrespective of clan affiliation, "Despite the complexity of the topic (Romani culture) there is consensus concerning the importance of the relationship between Roma and the *gadje*, the Roma word for non-Roma. Roma define themselves as distinct and different from gadje (Ringold 2005: 11). To be sure, different Romani groups will possess their own variations and may interpret and apply these practices to varying degrees of orthodoxy and stringency. Nonetheless it is important to recognize these "unifying" features of Romani health beliefs and practices.

Changing health care models

Written histories and gadje accounts of the Roma throughout their history in Romania are few and far between (Achim 2004). Very little empirical or qualitative information exists, from any period, to allow us to know more particulars about Roma attitudes toward traditional health and healing practices. In that sense, it is not possible to definitively speak about a "progression" or "evolution" of traditional healing practices because retrospective information and data are lacking. Moreover, due to their marginal position in Romanian society, and the fact that they did not have a written language until relatively recently, we also lack information about these attitudes and practices from a Roma perspective. However, there is a general concurrence that until the advent of communism in Romania most Roma subscribed to traditional methods of care not only because of the lack of facilities and physicians in their predominantly rural communities, but also because of the unassimilated, nomadic, and traditional nature of most Romani communities at that time. Romani groups would not have been the only groups adhering to folk or traditional medicine at this time, as other rural or isolated groups likely depended on their own variants of care (Kaser 1976).

Prior to the inter-war period Romania lacked a cohesive, integrated health care system. Most physicians were located in cities and towns, where they maintained private practices and pricing was unregulated. At that time, 84.5% of Roma lived in villages (Achim 2004). These rural areas were sorely under-resourced, lacking doctors and formalized medical facilities. After WWI, Romania adopted a Bismarckian health insurance system in which benefits were extended only to industrial workers, merchants, employers and their families. The health care system was financed through earmarked salary deductions which were matched by employers . However, these provisions insured only 5% of the Romanian population, and almost all of the beneficiaries were exclusively urban dwellers (Kaser 1976). In the case of the Roma, it is highly unlikely, given their predominance in rural communities and the lack of skilled Romani urban dwellers, that any significant number benefitted from the Bismarckian system. In addition, at that time most Roma were unassimilated and unintegrated, living on the periphery of Romanian society. As a result of these combined factors, it is believed that most Romani communities likely maintained their traditional methods of healing and care both out of necessity and preference until the end of WWII.

After the communist consolidation of power in 1948, Romania adopted a universal, Semashko-like system of health care provision, modelled after the one in the Soviet Union in which health care provision was centralized and universal. The introduction of the Semashko model was a drastic change from the Bismarckian system in philosophy, scope, and purpose. As a universalist system, the Roma were entitled to the same benefits as all Romanian citizens, and services were free at the point of use. This constituted a significant departure with the previous system, which had provided insurance and access only for a very small percentage of Romanians.

Despite the collapse of communism in 1989, the Semashko system remained shakily in place, though plagued by massive underfunding and in flux, until 1999. Thereafter Romania adopted the current national social health insurance (SHI) system which extends insurance coverage to formally employed individuals as well as their dependents. Social health insurance currently covers an estimated 83.4% of the residents in Bucharest, according to Dan Moraru at the National Insurance House in Romania (email to author, September 8, 2008). Insured persons are entitled to care from a general physician, who acts as a gatekeeper for specialized care, subsidized or free medication, hospital care and some dental procedures. For the uninsured all costs associated with health care and medication must be paid out of pocket.[2] However, all individuals, regardless of insurance status, have access to emergency services which are free and universal.

Roma in the post-communist context

It is now well established that the Roma, perhaps more so than any other group, have suffered the social and economic ills of the transition away from communism (Barany 2002, 2004; UNDP 2002; Kosa and Adany 2007). Roma are now the most impoverished population in Romania. Romani unemployment has skyrocketed, and this poor showing in the labor market is intimately related to the very low levels of education found amongst many Romani communities today. The lack of formal employment directly impacts their ability to receive health insurance, as SHI is conferred through employment. Without health insurance, as noted before, all associated costs of care must be paid out of pocket. However, given their very high levels of poverty, meeting these charges is likely challenging, if not impossible, for many Roma. The increasing marketization of health care in Romania has created a climate in which the receipt of health care is prohibitive for disadvantaged groups.

The changing economic conditions have clearly become increasingly constrictive for most Roma, on the one hand. However, at the same time, social liberalization since the collapse of communism has also allowed for the reintroduction and reclamation of religious, ethnic, and cultural expressions and practices which the communists attempted to minimize. Without the restrictions of communism, Roma (indeed, all ethnic groups) now have the freedom to organize and pursue the lifestyles and customs they prefer. Understood with these changing "push and pull" dynamics in mind, it is possible that a resurgence in traditional healing methods in Romani communities might be occurring. Thus, the present is an opportune time to try to gauge and better understand the application and relevance of traditional Romani health care beliefs and practices. Towards this main end, the following sections examine qualitative information gathered from Roma in Bucharest in 2009-2010.

Current attitudes toward traditional methods of health care

To explore these "push and pull" factors at this junction of change and transition in Romania, 43 in-depth interviews were conducted with Romani participants in Bucharest in 2009-2010. In an attempt to capture as much diversity of experience and opinion as possible, care was taken to locate interviewees with differing educational, employment, and income levels, as well as age (average age was 35; range = 18-72) and sex (23 women and 20 men) diversity. Within the interview group, the percentages of uninsured was very high – 75% for men, and 65% for women, but still consistent with findings from other researchers (e.g., Ringold, Orenstein et al., 2005). The low levels of insurance coverage are certainly related to the low employment rates in the interviewee group. For both men and women, the unemployment rate was over 50%,[3] and on average, the participants had only five years of formal education (levels of education ranged from "no education whatsoever" to advanced graduate degrees), making most formal work, which confers SHI, out of reach. In terms of equity, we can see clear differences between the current SHI system and the communist system. When health care was based on citizenship, all Romanians (including the Roma) had access to care. In contrast, among the interviewees only 25% of men and 35% of women now have health insurance, whereas 83.4% of all Bucharest residents are covered by SHI.

Despite the diversity within the participant pool,[4] as the interview findings will subsequently show, almost all of the interviewees expressed a strong rejection of traditional customs and methods of care, such as reliance upon healers instead of doctors. In addition, there was a similarly strong dismissal of the notion that ill health can be attributed to factors such as bad luck and impurity. It became evident in the interviews that although the division

between the Roma and the gadje historically has a central role in the sociology of Romani communities, none of the interviewees felt that interaction with non-Roma was harmful or contaminating. Indeed there was no reference to the notion or concept of the "gadje," nor was the term itself used. Interacting with non-Roma was considered quotidian and unremarkable, to the point where some interviewees were confused as to why a researcher would even be asking about this issue. Similarly, neither men nor women felt that female patients could not or should not be attended to by a male doctor because of concerns over purity. The proceeding sections more fully elaborate upon these findings.

Most respondents indicated a high degree of voluntary, intimate inter-mingling and interaction with non-Roma. One young woman explained, "I am half-Roma. My mother is of Roma ethnicity and my father is Romanian." Indeed, amongst the interviewees there were several families of mixed Romani and Romanian backgrounds. This was described as increasingly common by the respondents. Even for those without ethnic Romanians in their family, routinely engaging with non-Roma was presented as unexceptional. One older woman about to retire remarked, "I have worked with people who are not Roma my entire life, there is no difference. I have never felt different." Interviewees could privately hold to the notions of the gadje world as polluting, yet chose not to share that information in the interviews. However, this seems unlikely given the fact that their interactions and the conduct of their lives clearly demonstrate otherwise. [5]

Contrary to what traditional Romani custom would maintain, the apparent irrelevance of ethnic affiliation voiced by participants extended to relations with health care providers as well. All of the discussants had been cared for by non-Roma providers without issue or concern over purity, including Romani women being treated by non-Roma male doctors. For example, all women with children reported having delivered in a hospital often with male doctors, all non-Roma. Other typically private and taboo medical procedures were similarly carried out by non-Roma doctors as well, without any concern voiced by the participants. One woman explained, "Thank God the doctor helped me with this abortion! I don't even want to think about it… I have already four children. Maybe if I had a bigger house I would have considered having the child. But there is no room. He (doctor) really seemed to understand my problems." Male participants similarly did not express or convey any misgivings about their partners being treated by male, non-Roma physicians. When asked whether or not traditional beliefs about female modesty pose a barrier to seeking care one man replied:

> I don't think that this is so … some people may wait to see a doctor but that is usually because of the money problem…not really because a Roma woman cannot undress in front of a doctor. No, the Roma community it is not so much like this, they are not so closed and conservative anymore. They live an urban life, they know about things, and they know about so called 'dirty things' – they know. And so I don't think that this is a problem anymore.

A similar sentiment regarding female modesty and concerns over purity was expressed by one female discussant:

> No, I don't think that this (female modesty) matters at all…All of the doctors are Romanian, and they always have been so no one cares at all. Romani women can do whatever they want and undress and whatever else they need to do with a doctor, so this is not a problem. I think that these are very old ideas about what gypsies are like, but we are not like this anymore.

In addition to the proscriptions regarding female modesty and the polluting qualities of the gadje, participants were also invited to comment on their beliefs regarding traditional healing and understandings of the causes of illness. Interviewees neither reported nor alluded to relying on or giving credence to magic, spells, or traditional healers. Indeed, most of the respondents expressed a clear rejection of the relevance of or dependence on traditional healers. When asked if he felt that the Romani community preferred traditional healers to medical doctors, one interviewee replied:

> I don't think so…this (traditional healers) is bullshit, and people don't believe this anymore…I think that all the people know some advice to give – have a tea, take some rest. But I don't think that people can really give more advice than this. I don't think that people see these kinds of people (traditional healers) anymore.

Perhaps the most telling rejection of traditional Romani beliefs about healing was demonstrated by the respondents' health-seeking behaviors. The participants reported an overwhelming reliance on and preference for conventional modern medicine –none indicated a preference for healers or concoctions. The majority of the interviewees judged having access to a general practitioner (GP) to be very important, even among those who were not able to register with a GP.[6] Most of the female participants, and slightly less than half of the males, were registered with a GP. Among those registered, almost all reported using their GP as the first port of call when ill, as opposed to relying upon traditional healing methods. In describing what they do when they fall ill, patients would frequently make remarks such as this man's, "First of all I always go to the GP and then he sends me to a specialist for a more detailed examination."

Of the minority of participants not registered with a GP, none claimed to be unregistered due to scepticism about medical care or concerns over purity, and no objections to formal care were raised. Rather, practical obstacles for not registering with a GP were noted. Some cited the lack of relevant documents that are needed in order to register, "I wanted to register but I did not have an ID back then. And now I have one so I will go and register." Other uninsured participants cited inability to pay the out of pocket costs as a reason for not using a GP as a first port of call, "There were times that I did not go to the doctor because of the money, and I just took some pain killers…but if I did not have to pay, I would prefer to go see the doctor."

Only a few individuals claimed that they would ask for medical advice from someone in their community first, before consulting a doctor; however, it was the advice of friends of family in the community, not a "healer" that was sought out. As one man explained, "I really have big problems with my legs, I often cannot feel them. So I asked a friend about it and he recommended a cream that makes me feel a bit better." In almost all of the cases in which a friend or family member was consulted before seeing a doctor, inability to afford medical care was given as the reason, not scepticism of professional care. One young woman had a chest infection, but did not have insurance or the means to pay the doctor out of pocket. Instead she asked a neighbour for advice, "She advised me to make a mixture with vinegar and massage my chest with that to help loosen the mucous and the tightness … of course I would rather see the doctor, it's what you should do when you are sick, but I did not have the money at all."

Indeed among those unregistered with a GP there was a strong recognition that having access to a family physician was desirable, beneficial, and "proper." When asked if he would prefer to see a doctor when ill, one unregistered respondent replied,

> Yes, yes, I prefer to go to the doctors because doctors are very proper and you can say, oh, I feel sick here *(points to his side)* and they can look at you and work like this *(mimics an examination)* and he can say, "Aha! Here is the problem!" And then you can go to the pharmacy with the prescription and say that the doctor wants me to have this kind of pill.

It is clear from the interviews that much value is attached to receiving formal care, and because of that value, the poor and the uninsured often expressed a willingness to borrow money in order to seek out care, "During the period I wasn't employed I borrowed money from my mother or sister. That's what I and my siblings do, we help one another. If one of us has the possibility, he helps the others, and so on." Another woman explained how she and her husband had to borrow 600 euros with interest from a money lender to afford a procedure for her elderly mother.

When ranking where Roma primarily go for health care, pharmacies came after family physicians for many respondents. Many participants who visited the pharmacy before seeking the care of a doctor explained that their ailments were either minor or reoccurring, and therefore they knew the right medication to purchase, "Because I only have problems with my tonsils, I already know what kind of medication I need and I prefer to go and buy it directly from the pharmacy." However, even among those who preferred to visit the pharmacy first indicated that they would seek care from a physician if their situation did not improve, "I would rather go to the pharmacy. I know that in the pharmacy I can get what I need…but I would go to see a doctor if it got worse."

Nearly all participants had received treatment in a hospital either as an in-patient or from emergency services. A small number of participants, all of whom lacked insurance and did not have a GP, cited that the emergency room (ER) is their first port of call. As emergency services are free, it is understandable that this option would be appealing to some.

Interpreting the interview findings

Interviewees clearly asserted an overwhelming commitment to and preference for formal health care provision without cultural reservations. Importantly, none of the subjects indicated that they rely upon or defer to traditional means of healing when they fall ill, either as a first option or in instances when they cannot access formal medical care. Moreover, there was clearly an acceptance of bio-medical explanations for illness, instead of traditional understandings centered on misfortune and supernatural forces. The question then becomes what factors can help explain this apparent diminution of traditional models of health care?

Cultural transformations of this sort are complex, multi-faceted, and cannot be facilely explained. It is well established that broad societal changes such as industrialization and the effects of modernization often lead to more secular attitudes in societies (Abrahamson 1976). Indeed, Romania experienced unprecedented industrialization, modernization, and urbanization from the early 1950s through the 1980s, and these changes will be discussed further. No doubt these wider social forces of urbanization, modernization, and industrialization helped to influence the Roma's – indeed all groups' – changing attitudes over time. However, the exact mechanisms and factors that drove this secularization are important to understand. It will be argued that, within the myriad of factors which played a role in this process of attitudinal transformation, examining first the stringency of the enforcement of the Semashko system, and second the processes of systematization and assimilationist strategies in Romania are particularly illuminating and instructive factors to consider.

As discussed earlier, Romania adopted a Semashko health care model based on the Soviet model in 1948. The main tenets of this health care model included abolition of private practices, single and unified health care services provided by the state, free services, emphasis on preventative care, and universalism. Because the model nationalized all health care facilities, every provider then became salaried state employees (George and Manning 1980; Cockerham 1999).Because of the universal nature of the new system, access to formal health care became based on citizenship, and therefore extended to the Roma as well. All Soviet satellites adopted Semashko-like health care systems, however the Romanian Communist Party (RCP) demonstrated greater stringency in the application of the new health system than many other countries in the region.

At the time of the adoption of Semashko, Romania lagged significantly behind many other countries in the Soviet sphere in terms of industrial development as well as human development indices such as literacy, life expectancy and mortality rates. Thus, rapid improvement in health care was seen as an integral part of modernizing the labor force. In this pursuit, the RCP mandated full, compulsory enrollment in the health care services, decreeing that all citizens must be registered at a polyclinic, and that annual medical examinations, pre and post-natal care, vaccinations, and immunizations were all unconditionally obligatory. Romanian citizens who did not adhere to these regulations could face punitive action. Practitioners were subjected to similar punitive measures if they were found to not be in compliance, according Dr. Silvia Gabriela Scintee, Deputy General Manager of the National School of Public Health, Management and Professional Development in Bucharest (interview with author, November 22, 2009).

To avoid such legal action, some health care providers felt compelled to go door to door strongarming patients to register at the local polyclinic. These tactics were perhaps more commonly found in the countryside, where individuals had historically lacked access to facilities and doctors. Having relied mainly on self-help (both Roma and non-Roma) until that time, there was more rural resistance to and suspicion of the sweeping changes. Because health care provision was based on citizenship and was compulsory, for many Roma the introduction of the Semashko system mandated their first encounters with modern medicine.

The implementation of these heavy-handed requirements contravened many of the traditional Romani beliefs about health and care, including the importance of maintaining separation from the gadje and reliance upon healers and traditional medicines. Also, the new medical system firmly assigned causes of ill-health to biomedical, not spiritual, factors, and as a result, medication, vaccinations, and immunizations were forced upon Roma. The legacy of the communist health care arrangements undoubtedly played a role in eroding adherence to traditional beliefs about care, as it was designed to do to help "modernize" Romania.

Set alongside the stringent health care laws were the processes of assimilation and systematization, which sought to neutralize cultural and ethno-religious expressions among ethnic minorities in Romania. The RCP stridently pursued assimilationist policies toward the Roma, as well as other ethnic minorities (Gilberg 1981; Gallagher 1995). Most communist governments tried to minimize cultural, religious and ethnic affiliations; however, the RCP was exceptionally tenacious in this pursuit. The aim was to erase all ethnic cleavages and to recast all citizens as undifferentiated "Romanians" – a process referred to as "Romanization." Romanization sought to draw citizens' allegiance and dependence away from ethno-religious networks and kinship, and redirect them towards the state instead. To help "deconstruct" Romani communities the RCP forcibly settled the Roma by confiscating all wagons and horses to discourage traditional nomadic lifestyles (Barany 2002). Further, "Roma" as an ethnicity option was deleted from all census data, forcing all Roma to self-identify as Romanian. Moreover, the teaching of the Romany language was forbidden in schools, and it was actively discouraged in public and at the workplace. Romani music, which had been very

popular even among non-Roma, was banned (Brearley 2001). In comparison to other countries in the communist bloc, these measures were undoubtedly heavy-handed. Yugoslavia, for example, although not within the Soviet sphere, allowed for much greater Romani cultural expression and language retention (Barany 2002), and the Yugoslav government continued to recognize the Roma as a national minority (Puxon 1987).

The RCP's policy of systematization can rightly be seen as hand in glove with Romanization in its attempt to erode Romani (and other ethnic groups) identity. The policy of systematization was "the ultimate attempt to eradicate all vestiges of pre-socialist or pre-Ceausescu national culture and help create the new 'socialist Romanian citizen' by destroying the bonds of solidarity that existed in the villages" (Schopflin and Poulton 1990: 18). For the RCP the "village" represented anti-modern backwardness. Therefore, the ethos of systematization was to modernize and help construct a 'new socialist Romanian citizen' that was disabused of archaic notions of ethnicity and religion, and instead identified first and foremost as Romanian socialist. Some observers consider systematization an unequivocal attempt to erase ethnic identity all together (Schopflin and Poulton 1990). In an effort to achieve this end, the RCP resettled Romani families (and other ethnic groups) into nationalized houses, mainly in urban areas, ostensibly to increase the number of industrial workers (Hale 1971). Many Roma were also relocated to new agro-industrial towns to service the collectivized farming industry. However, the resettlement was also intended to disperse compact, endogamous Romani communities, and to assimilate and integrate them among ethnic Romanians (Barany 2002). This forced "opening up" of traditionally closed-off Romani groups was viewed as vital to deconstructing what was seen as their superstitious, backwards, and clannish lifestyle. The net effect was a higher concentration of Romanian Roma living in cities exposed to urbanization, as well as the deconstruction of traditional Romani ways of life. This process made the Roma less reliant upon their own kinship networks. Instead, for many Roma, the Romanian state supplanted the role of Romani traditions in the provision of education, housing, employment, and health (Barany 2002).

Conclusion

The purpose of this investigation was to explore how Roma today view and utilize traditional methods of health care in light of social liberalizations and the increased marketization of health care in Romania today – the so-called "push and pull factors." Inquiries of this sort are lacking and are needed to help understand the current health needs of the Roma today. The analysis based on the interviewees' responses revealed that, despite the prohibitive economic climate to accessing health, and irrespective of the newfound ability to reclaim ethnic traditions, there was a strong preference for formal medical care. This point was powerfully demonstrated by the reported health-seeking behaviors of the Romani interviewees, which indicated a clear rejection of traditional means of health care. Although it is generally accepted that prior to the communist assumption of power most Roma in Romania likely relied upon traditional forms of medicine (Achim 2004), there are no concrete data to facilitate comparisons between how orthodoxy and adherence to traditional medical beliefs has evolved over time. However, the interviews help to construct an important retrospective view on traditional health beliefs by discussing current perceptions and practices, while often drawing comparisons to the past. This was particularly true when, for example, interviewees would talk about traditional healers and claim that "no one believes in that nowadays," or in regard to female purity, how these notions are, "old ideas about how gypsies are." In these comments and others, the participants provide an important window through which we can glimpse, from their perspective, how Romani attitudes toward traditional health care practices have changed. Indeed the interview findings suggest that the

participants, while recognizing these beliefs and practices, regarded them as outmoded vestiges of the past. It was argued that this seeming cultural shift away from traditional medical beliefs and practices can be partially related to broad societal changes in Romania such as urbanization, industrialization, and modernization, as well as the RCP's specific policies of systematization and assimilation.

As these interviews were conducted in an urban area, it could be suggested that the findings overlook potential differences between urban and rural populations. However, while information and data are still lacking, there is some evidence to suggest that the attitudes and beliefs expressed in this urban sample may have resonance in rural populations as well. One of the only studies to examine health attitudes and practices among both urban and rural Romanian Roma found that only 1.1% of the nearly 8,000 participants reported using "incantations" or magical spells to help heal an ill person (Cace and Vladescu 2004). In contrast, 24.3% in the study reported going immediately to a doctor (for those with children, this percentage rose to 30.4%) and following that, 31% indicated that they would wait for a while and if it did not pass would then go to a doctor. Although more investigations are clearly needed, this data in combination with the research presented herein indicates that overall acceptance of traditional methods of care seem to be increasingly abandoned in favor of conventional, modern health care amongst many Romani communities irrespective of regional differences.

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[1] To be sure, these "push and pull" factors do not solely affect the Roma. However, the Roma are the focus of this inquiry because vis-à-vis other ethnic groups in Romania (Hungarians, Serbs, Germans, inter alia), the Roma have been more negatively impacted by the post-communist transformations than other groups (Barany 2002, 2004; UNDP 2002; Kosa and Adany 2007). Specifically, compared to other ethnic groups in Romania, fewer Roma have access to medical care and are more impoverished; they therefore may need to be more reliant upon alternative forms of health care. However the premise of this study could well be applied to investigate other ethnic groups in Romania, or even ethnic Romanians.

[2] Certain categories of people such as children until the age of 18, the disabled, heroes of the Revolution, and war veterans, among others, are entitled to non-contributory, free health insurance regardless of work status. Persons who have been diagnosed with certain life threatening and chronic illnesses are similarly entitled to these benefits.

[3] This percentage does not take into account informal, or "grey economy" work. Many Roma are informally employed which generates income, but it does not confer health insurance.

[4] There was an attempt to determine which clans (e.g., Kalderash, Vlach, etc.) the participants belonged to. Some of the participants were unsure or did not know. Others indicated that their ancestors had "belonged" to a particular group, but that they did not personally feel affiliated, nor did they self-identify as belonging to that group. Some were aware of their clan membership – primarily Kalderash and Ursari. However, based on the responses, it is clear that the large majority shared the same feelings about the traditional beliefs and practices, irrespective of individual clan affiliation or lack thereof. In that sense, within this sample, clan affiliation did not influence responses.

[5] The author is non-Roma, and therefore it is possible that participants reconfigured their responses because of discomfort or ill-ease. However this appears unlikely for a number of reasons: the interviews were conducted by a Roma interviewer recruited from University of Bucharest. Also, the author, while not Roma, is of Indian descent. Before the interviews commenced, participants were explained the nature of the interviews and were introduced to the research team (interviewer and

author). There was a recognition and acknowledgement amongst the participants that Roma historically come from South Asia – as such, the author was called "soră" (sister) by the interviewees, implying a level of trust. Observationally, the participants' body language did not communicate distrust or unease and indeed after the interviews, in some cases, the research team was invited to eat snacks and drink tea with the family of the interviewee – again, implying a level of trust.

[6] In order to register with a GP, the patient must present certain documents. Some of the interviewees did not have the necessary documents and were therefore unable to register despite their desire to be registered.

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