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CULTURAL COMPETENCE IN EPIDEMIOLOGICAL FIELD WORK WITH CULTURES IN FLUX: ROMANIA

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ABSTRACT

This article is a case study of conducting field-based epidemiological work in a former communist country. A brief background of Romanian history and culture is followed by discussion of the challenges of doing epidemiological science in a culture experiencing socio-political flux. In this former communist country where a common understanding of specific methods of epidemiological science and research ethics is not necessarily shared by both visiting and indigenous scientists, successful fieldwork depends on a high degree of understanding, sensitivity, and patience. The United States Department of Health and Human Services' Office of Minority Health, OMH provides guidelines for culturally competent care that, while originally designed for use in patient-provider care settings, can provide insight and direction in the practice of epidemiological fieldwork. The OMH guidelines are provided, and they are discussed in relationship to fieldwork where appropriate.

INTRODUCTION

While draft standards and operational definitions of cultural competence in health services are currently published for public review and comment (Federal Register, December, 1999), many individuals and organizations conducting cross-cultural health science endeavors are learning directly or indirectly through experiences of others how to "do" culturally competent health promotion and health research in diverse settings. The recommendations for National Standards in Assuring Culturally and Linguistically Appropriate Health Care Services (CLAS) were developed through the Department of Health and Human Services' Office of Minority Health. The draft standards were developed through scientific review of existing documents and is an effort designed to develop consensus and common language for health services around the country, wishing to provide competent delivery for increasingly diverse populations. While very necessary and useful, these recommendations are currently limited in their application to direct health care service provision, primarily in the United States. In contrast, with emphasis on patient communication and oral and written translation efforts, collecting primary data in cross-cultural settings often requires additional skills, activities, and cooperative relationships.

This article is a case study of conducting field-based epidemiological work in a former communist country. This work is based on an epidemiological study conducted in rural villages in Romania to assess methemoglobinemia (MHG) risk factors in Romanian Children. This work involved gathering source information along with biological and environmental sampling. These activities were conducted in conjunction with Romanian scientists throughout the Transylvania region of the country (see Figure 1).



Figure : Map detailing the Transylvania region of Romania

In the course of these efforts, barriers to culture and language were addressed in order to move the work forward. The cultural challenges detailed in this article may help inform future researchers in similar endeavors. The definition of culture that guided these efforts is a frequently cited definition developed by the Office of Women and Minority Health at the Bureau of Primary Health Care, Health Resources and Services Administration (HRSA): “Culture is the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people” (Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services, pg 2). Another common definition is that ‘ a Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups” (Goode, Sockalingam, Brown, & Jones 2000).

ROMANIAN BACKGROUND

The history of Romania and the Transylvania region of Romania is quite different from that of the United States. Since at least 106 A.D., invading armies and imperialist regimes have targeted Romania and the surrounding countries of the Balkans for their expansionist purposes (Hoffman 1963). The Roman Emperor Trajan was one of the first to establish imperialist rule in this region followed by a long succession of invasions, migrations, and conflicts (Cadzow et al. 1983). For example, Emperor Aurelian, a Goth, in 271 A.D. drove out the Romans and the Attila of the Huns pushed out the Goths in 376 A.D. When the Attila died, the Gepids controlled the area who were forcefully dis-

placed by the Khan Bajan of the Avars and so goes the history of the Transylvania region as the Bulgarians, Hungarians, and Petchenegs, among many others, imposed imperialist or authoritarian regimes (Cadzow et al. 1983). Most recently, from the 1940's through 1989, the Russians and the Soviet Alliance exerted an authoritarian, communist political regime in the region (Cadzow et al. 1983). In late 1989, a violent change in political leadership resulted in upheaval in most sectors of Romanian leadership, including changes in the health system (see Figure 2), (Enachescu 1998). As with any sudden large scale political upheaval, changes in leadership preceded most planning efforts regarding maintaining adequate health care services. The rapid dismantling and liberalization of the health care system led to unanticipated consequences in health care delivery, services, and outcomes, especially for the poor.

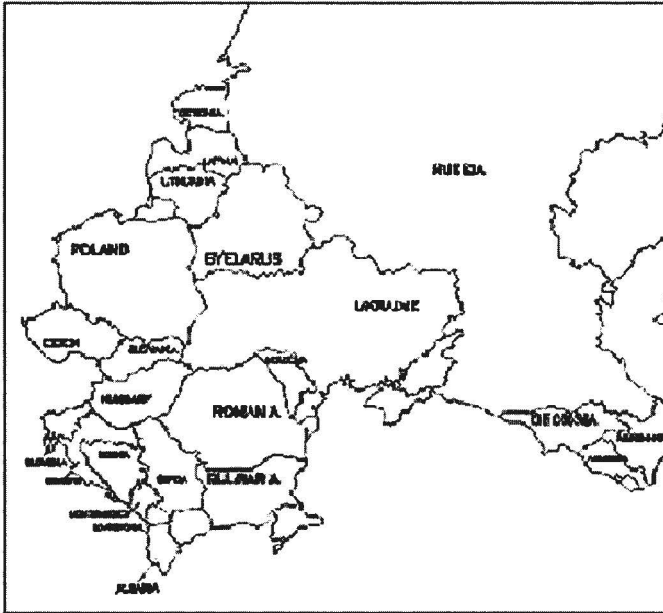


Figure 2: Map detailing Eastern Europe and the Newly Independent States of the former Soviet Union (NIS)

The “health crisis” of former communist countries refers to this considerable transition from a centralized, state-controlled health care system, toward increased privatization without adequate resources (Muresan, 1999). Combined with rapid socioeconomic changes, increased poverty and unemployment, and post-communist changes in politics and cultures, health indices in many countries of Central and Eastern Europe, including Romania, have seen complex changes with some indices worsening and some improving. From the period between 1990 and 1998, infant mortality rates (per 1,000 live births) dropped from 27 to 21 and the under 5 mortality rates (per 1,000) dropped from 36 to 25 (U.S. Agency for International Development 1996; World Factbook 1999). However, Romanian males have experienced recent decreases in average life-expectancy at birth. Although Romanian life-expectancy at birth remains above those of the former

Soviet Union, males in Romania have life expectancies at birth that are shorter by 8.7 years (average; 65.3 years) compared to life expectancies of males in Western European nations such as France (Muresan, 1999).

When working to accomplish epidemiological research goals in cross-cultural settings, an understanding of the culture and history of both the research collaborators and the subject population is crucial to success. Politically and collectively American and Romanian cultures have experienced far different histories and developed different concepts of the individual within the collective enterprise of politics and, by logical extension, other collective efforts, such as science (Nelson 1991). One of the important characteristics discussed by political and cultural analysts concerning the region is the constant experience of ethnic cleansing and forced assimilation that the regions of the Balkans and Romania have experienced (Brown 1992; Tindemans et al. 1996). The individual Romanian scientist has had to adapt and practice their art in a climate of authoritarianism quite different than that experienced by the American scientist. In Romania, in particular, the *intelligentsia* (academics and highly educated peoples) were the most persecuted of the Romanian groups by the *Securitate*, often living and working in a climate of fear of persecution. The overarching political regime had its own agenda which, at most times, did not allow for the free expression of scientific ideas, especially as they might reflect on the regions public or environmental health policies and practices (Nelson 1991).

CROSS-CULTURAL CHALLENGES AND SCIENCE

The supposed “common” language of science may not be as universal as the researcher imagined when they first embarked on a project. The concept of science as a cultural construct, rather than a purely objective endeavor is then exposed.

Each of the parties in the cultural exchange comes to the endeavor with traditional practices and beliefs in science shaped by their own cultural experience which includes a political reality (Harris 1980, 1981). The political and cultural realities of the American and Romanian experience are distinctly different. American’s come to the exchange with a history of open and untethered participation in the Western scientific process (Nelson 1991). This participatory practice is predicated upon the concept of the individual, within the framework of scientific practice, searching for truth and having the academic freedom to express those truths without the fear of reprisal or suppression (Garraty and Gay 1986, Palmer and Colton 1978). These concepts are further imbedded in the political freedoms ensured by *individual* liberty functioning within the political framework of a democratic republic (Palmer and Colton 1978). The history of the United States as a collective dates to the 1700’s where a successful revolution grounded in these principles established the Republic which has, for the most part since that time, enjoyed relative internal stability and economic prosperity. Certainly exceptions to this general rule occurred (the Civil War, World Wars I and II) but in the majority of these conflicts, due to tactical, military and technological skill, and the economic muscle which supported these, the United States was able to maintain its collective identity and persevere against its aggressors (Garraty and Gay 1986, Palmer and Colton 1978).

These differences in cultural and political experiences can impact a number of areas in joint scientific work (Acha and Gureje 1994). Requirements commonplace in the United States such as the informed consent practice associated with the concept of ensuring and protecting individual rights and liberties can appear to be unnecessarily time consuming and burdensome to Romanian scientists who have not previously had to abide by such standards. Explaining the concept as assuring the free and open participation principle of the research interaction, lest we forget the abuses of the past, can be frustrating and time consuming for all parties as can be ensuring that the rule and intent of privacy and informed consent is put into practice, for example, being cautious to safeguard the identity of the individuals in the study from others not directly associated with the work, such as public and governmental authorities or the news media.

These concerns are further complicated by the need to communicate/translate between two languages (Putsch 1985). Different languages have very different obligatory categories; the way the languages express action, actors, gender, social standing, etc. When designing questionnaires or survey instruments, the need to work carefully through these concerns with a qualified interpreter, and to pilot the survey is very important to the success of the project (Kroeger 1983). Further, developing a personal, working relationship with the interpreter is essential to the success of the project (Putsch 1985).

As an illustration of how these cultural differences may manifest, during a recent conference on infantile methemoglobinemia in Satu-Mare, Transylvania Region, one of the physicians who had practiced for decades in the rural villages noted that under the Soviet Alliance, physicians were instructed to tell villagers that MHG-related health problems were caused by diarrheal disease or malnutrition, not by drinking water contaminated with nitrates (Anonymous 1999). In a follow-up conversation with another scientist, a microbiologist involved in water quality testing, the scientist explained that the previous political regime was not committed to the development of the rural villages and wanted instead to encourage migration to the urban areas and to industrial jobs (Anonymous 1999). Thus, developing the rural villages for the peasantry was not considered a priority, nor was the acceptance or dissemination of scientific information that might indicate a need to take political action in that regard.

IMPACT OF CULTURE CONCERNS ON ROMANIAN MINORITY GROUPS

The difficulties of working cross culturally and differences in approach to science can also affect the nature of communicating knowledge, choosing research areas, and the validity of findings. For example, previous regimes in Romania were very concerned with the authoritarian concept of equal rights for all regardless of nationality (Brown 1992). Discussion or evaluation of racial or socio-economic difference as a risk factor in epidemiological concerns or other areas of society were overtly discouraged because everyone was "equal" (Brown 1992). While perhaps well intended in theory, an authoritarian approach to the issue of ethnic minorities does not allow either the minority groups nor the majority groups to explore their tensions, differences, and concerns in an open and democratic fashion (Tindemans et al. 1996).

The Roma people (often referred to as Gypsies) number more than eight million worldwide, with approximately 5.2 million Roma living in Central and Eastern Europe (Brearley 1996). The single largest population of Roma today can be found in Romania (Pavel 1991). The Roma peoples have historically been treated with hostility and suspicion, if not outright oppression and persecution (Brearley 1996; Fonseca 1995; Cohn 1973). For example, most of the Gypsy population endured World War II in concentration camps such as Auschwitz and Buchenwald (Brearley 1996; Fonseca 1995; Alt and Folts 1996). Roma peoples were concentrated into special sections within these camps for both medical experimentation and extermination (Alt and Folts 1996; Kenrick and Puxon 1972; McDowell 1970). To illustrate the extent of their travail, Holocaust scholars report that more than 75% of Poland's Roma population was executed by the Nazis (Kaminski 1981; Greenfield 1977). While current surveillance data in former communist countries are sparse, the economic realities of many Eastern European countries including Romania, have made it even more difficult for Roma peoples to obtain good housing, nutritional food, reasonable employment, and health care (Fenyvesi 1996; Brearley 1996; Pavel 1991). An additional burden Roma peoples face, that is even harder to quantify, is the constant threat of ethnic cleansing as well as acts of individual violence (Fenyvesi 1996; Brearley 1996; Pavel 1991).

Thus, if a scientist, during previous regimes, were evaluating whether there was a disparate risk of infantile methemoglobinemia for varying minority groups, they might be censored and/or discouraged. While peer pressures and the dogma of accepted wisdom can function to pressure the American scientist in regard to research choices, the government is not known for its role in actively discouraging particular areas of scientific work. In the post-communist countries, the fear of censure for exposing "problems" and the censure of science endures.

An additional illustration of the lasting impact of political history on epidemiology and health surveillance is the continued absence of scientific investigation concerning minority populations' health status in Romania and other former communist countries. Recent literature searches revealed a paucity of data regarding the health status of Gypsies or Roma peoples. The majority of the literature related to Roma peoples were anecdotal, community health practice articles largely occurring in nursing journals.

Sharing of theories and research through peer review processes such as professional colloquia and conferences which are commonplace in Western cultures may be unfamiliar and uncomfortable to scientists and researchers in newly independent states. While scientific and academic discourse are rarely free from socio-political constraints, on a continuum of unfettered discourse, it must be recognized that the U.S. is at the opposite end from former communist countries and that it will be difficult for Americans to anticipate the enduring nature of these constraints. Questions which cannot be raised due to perceived fear of political ramifications extinguish the intellectual fires of the scientific process.

The following recommendations are adapted from the Department of Health and Human Services' Office of Minority Health CLAS (Draft Standards on Culturally and Linguistically Appropriate Health Care) published in the Federal Register (December 15, 1999) for public review and comment. The adaptations involved tailoring a number of

the 14 recommendations to cross-cultural epidemiological/research work rather than direct health care service provision, with each relevant point followed by details of how this was implemented in Romania.

Although this paper primarily dealt with experiences related to research field work in rural Romania, current plans include continuation of the original work by further assessment of water quality issues, implementation of an infant feeding survey and delivery of public health training to health care workers related to infant feeding practices. As such, brief comments regarding planning for a more direct-service health care project are included.

RECOMMENDATIONS

- 1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with [colleagues, administrators, participants and] patients and each other in a culturally diverse work environment.*

Cross-cultural field research involves cooperation and collaboration with many different individuals and agencies. It would be of great benefit to all researchers involved in cross-cultural work to receive cross-cultural sensitivity training before embarking on the project. This training should include some of the basics concerning culture; what it is, how anthropologists conceptualize culture, and how to find out more about other cultures. General didactic knowledge of a given region or population is still not adequate preparation for the diversity within any given culture. Knowledge regarding scientists and scholars surviving under strict communist regimes does not prevent the culture shock of experiencing the results of historic repression of creativity and innovation. While reluctance to change may be part of general human experience, a cultural milieu that has discouraged change and risk-taking still pervades many aspects of the health care system.

Culture shock is a well established anthropological phenomena. All cultural anthropologists are well versed in understanding and recognizing it as they live and work for extended periods in field settings. The phenomena, once experienced, truly aids the anthropologist in understanding what is culture: a way of living and doing life, technology, morals, etc, common to and commonly embraced by a distinct group of individuals (Harris 1980). It is a roadmap to living written in a common language and walled in by religion, morals, and values (Harris 1980, 1981). If experienced cultural anthropologists could provide suggestions and viewpoints on overcoming communication difficulties and culture shock, it might greatly improve the quality of individual efforts and the enjoyment of the experience as a whole.

- 2. Have a comprehensive management strategy to address culturally and linguistically appropriate [goals and] services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.*

Once a collaborative infrastructure of appropriate contacts is in place, continued sharing and understanding of the evolving project is crucial to success. Flexibility in plan-

ning and oversight regarding procedures may be of particular importance. From practical experience, a time-line and/or agenda for actual field work including time for interviewing and data collection needs to be over-estimated. The American experience of both work-ethic and time constraints cannot be imposed on other cultures. Romanian's experience of a typical work-day is very different from American's in regard to quantity of work accomplished versus the quality of the work experience. Romanian working professionals typically experience shorter work days than Americans and may enjoy up to six weeks vacation per year.

- 3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.*

Involving stakeholders in all relevant phases of planning and implementing is of paramount importance in the success of any community health endeavor (McDermott & Sarvela, 1999). In cross-cultural work, it is important to first understand the existing infra-structure for public health and second to communicate and collaborate within the existing structure. This phase of cross-cultural work is particularly time-consuming. It is useful to remember that much education occurs through this process of collaborating and exchanging knowledge and ideas regarding the project. While the aim of most community health work in the United States is to empower individuals and communities with skills and tools to enhance their efficacy regarding a given health condition or practice, the entire premise of this type of work is not only relatively new and unfamiliar in post-communist countries, but is the antithesis of assumptions under which they have been operating for generations. The entrenched and inflexible nature of many of the structures for health care delivery and service in post-communist countries requires great patience and diplomacy.

- 4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.*
- 5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.*
- 6. Provide all [contacts] clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.*
- 7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.*

8. *Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.*

9. *Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.*

The interpreter should be versed in the scientific terminology of both languages and the researcher should make every attempt to learn some of the language in an effort to communicate effectively with both interpreter and study participants (Putsch 1985). If data collection involves interviews conducted by colleagues from the dominant culture (Romanian), the researcher should attempt to qualitatively assess the validity of the interview process. The comfort level of the participants and the interviewer can impact the accuracy of the information obtained (Putsch 1985).

10. *Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.*

11. *Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.*

All instruments and assessments used to collect data need to be first beta-tested by the cross-cultural contacts and collaborators, but also pilot tested in the community. While validity and reliability of research instruments is always a consideration in health research, these issues become more complex in cross-cultural work. While the initial problems may be related to translation and linguistics, there are many unforeseen issues that can occur. Problems related to quality control in data collection efforts may differ greatly between cultures. For example, in spite of training local staff to administer interview surveys without bias or prompting, there exists a tendency to please officials and administrators that may contribute to inaccuracies in conducting and completing the interview. Indigenous experts' involvement and understanding in all aspects of refining and implementing instruments can help to reduce these potential problems.

As stated earlier, communist regimes often assumed that everyone was equal and hence, asking questions or gathering data related to minority groups was actively discouraged. Although the investigators may feel it is crucial to the work to gather data related to ethnicity and race, under some circumstances this may be very difficult or may compromise working relationships.

12. *Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.*
13. *Develop structures and procedures to address cross cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.*
14. *Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.*

While the Draft Standards on Culturally and Linguistically Appropriate Health Care are generally intended for use in Health Service Delivery settings in the United States, they provide a strong starting point for cross-cultural work in other countries. Although each cross-cultural endeavor is unique, the history and experiences detailed in this paper may serve as a guide for future endeavors. Many of the people in post-communist countries share similar histories of cultural oppression, reluctance to engage with people from democratic or capitalist countries, and fear of reprisal from the state for venturing outside of standard practices. Additionally, the health care needs of many of these countries is very high, as their economies and formerly state controlled systems of health care are in serious flux. As post-communist countries in Eastern Europe increasingly encourage collaboration and partnerships with other countries, projects which focus on health care services will find that in-depth knowledge of the history and culture of the population can serve to ameliorate potential pitfalls in planning, implementing, and evaluating stages of the project.

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