REFUGEES AND HEALTHCARE PROVIDERS IN ANCHORAGE, ALASKA: UNDERSTANDING CROSS-CULTURAL MEDICAL ENCOUNTERS

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ABSTRACT

Refugees are part of the increasing cultural and ethnic diversity of Anchorage's population. With over ninety languages now spoken in Anchorage homes, this trend has implications for the delivery of culturally appropriate healthcare services. This paper examines cross-cultural medical encounters between healthcare providers and refugees in Anchorage. In-depth, semistructured interviews were conducted with healthcare providers (n = 10) and refugees (n = 9). These qualitative data were analyzed for thematic content regarding healthcare barriers, cross-cultural challenges, keys to success, and areas of agreement and differences in perceptions. Conclusions were that refugees in Anchorage had a generally positive perception of local healthcare providers who display cross-cultural empathy and take time to establish trust despite time limits, lack of mental health services, language difficulties, and differing health beliefs. Steps should be taken on a provider and organization level to address identified barriers and challenges.

KEYWORDS: Hmong, Sudanese, sociolinguistics, medical anthropology, folk beliefs, refugees

INTRODUCTION

The migration of displaced peoples to Alaska, such as refugees and asylees (individuals who were granted asylum while in the U.S.), is a sign that globalization is increasingly penetrating the Last Frontier. Hence, applied anthropologists need to move away from solely focusing on Alaska Native issues to issues affecting people with diverse ethnic backgrounds. As a city, Anchorage has already begun to recognize that many of its residents are displaced peoples from all corners of the world. In Anchorage, World Refugee Day is an annual celebration in June with a well-attended community event featuring music, dancing, food, and children's activities. The event is organized by Catholic Social Services' Refugee Assistance and Immigration Services (RAIS) program, the agency responsible for facilitating the resettlement of refugees in Anchorage. RAIS provides assistance in many aspects of refugees' new lives, including cultural and linguistic support to access medical services and coordinating the federally mandated initial health assessment (or medical screening) for all arriving refugees. The U.S. Office of Refugee Resettlement states that the initial health assessment sets the stage for refugees' entry into the U.S. healthcare system, which may be very different than healthcare in refugee camps or countries of origin and represents the gateway to continuing medical care (Lee 1995). This paper analyzes which factors are involved with success in, and barriers to, healthcare provision for refugees living in Alaska (see also Jessen 2009).

Alaska has a very diverse refugee population, but receives relatively few refugees compared to states such as California or Texas, which resettled 16% and 8.5% respectively of all refugees admitted to the United States in 2008 (Martin and Hoefer 2009). A systematic literature review did not reveal any pertinent information regarding

refugees' healthcare experiences in Alaska. To address this gap, this study examined medical encounters between Anchorage healthcare providers and refugees, including asylees. This pilot study identified barriers and challenges but also highlighted successful pathways to providing refugee healthcare by asking:

- What are the keys to successful medical encounters between healthcare providers and refugees or asylees?
- What are barriers and challenges of providing healthcare to refugees?
- How do refugees perceive the healthcare services that they receive in Anchorage?

ALASKA'S REFUGEE POPULATION

In 2004, a series of *Anchorage Daily News* articles (e.g., Bronen 2004; Tsong 2004a, 2004b) brought the arrival of new Hmong refugees to the public's attention. While conveying awareness of the history and the struggles that Hmong refugees endured before finally reaching Alaska, these articles familiarized Alaskans with Hmong culture, shared stories of success, and gave insights into the process of integration into the Anchorage community. A group of refugees that has also received attention in the local news is the Sudanese community, which established a nonprofit organization, the South Sudanese American Community Association (SSACA) (Bluemink 2008). This association provides outreach to southern Sudanese refugees who moved to Alaska from other states and need assistance relocating. Newly arrived refugees, such as those from the genocide-torn Darfur region in Sudan, may find a support system through SSACA but are also served by the RAIS program at Catholic Social Services.

The services that the RAIS program provides to its clients include housing and employment assistance, case management, cultural and linguistic support, enrollment in English language and other training classes, as well as coordination of federally mandated health assessments, which are separate from general medical care but are often the introduction to the U.S. healthcare system. When newly arrived refugees come to Anchorage, they have to undergo a two-step health assessment (Dr. Karen Ferguson, director of the Refugee Assistance and Immigration Services, pers. comm., 2008). The first step involves the municipal health department for tuberculosis screening and immunizations, and the second step involves the Anchorage Neighborhood Health Center, a federally qualified community center, for physical exams and lab tests.

The RAIS program serves about 1,060 clients. These clients have typically come to Alaska as refugees from their countries of origin but also include refugees who moved to Alaska after their initial resettlement elsewhere in the United States (secondary migrants) and asylees. The majority of refugees are Hmong originally from Laos, followed by refugees from the former Soviet Union, and nationals from various African countries, including the Darfur region of Sudan within the past two years. The Hmong community estimates that there are about 5,000 to 6,000 Hmong in Alaska, and the overall Sudanese population is thought to be about 1,000, the majority of whom are southern Sudanese (Karen Ferguson, pers. comm., 2009).

The statistics published by the Office of Refugee Resettlement for FY 2008 (Office of Refugee Resettlement 2009a) show that Alaska welcomed fifty-two refugees overall, of which sixteen came from Sudan, fifteen from the former USSR, ten from the Democratic Republic of Congo, eight from Togo, two from Iraq, and one from Ethiopia. These numbers also include refugees who came to Alaska in the context of family reunification, but not secondary migrants who made up the majority of refugees in Alaska prior to 2004. Table 1 shows data on refugee arrivals in Alaska between 2000 and 2008. The low numbers are probably due to the fact that Alaska has a comparatively small population, a labor and housing market that may not have the capacity to absorb large numbers of refugee arrivals, and the fact that Alaska did not have a refugee resettlement program until 2004. Data are only available after 2004, when the RAIS program took on initial refugee resettlement in Alaska (Karen Ferguson, pers. comm., 2008). Alaska's new refugees were primarily Slavic and Hmong before 2008. Since then, however, the refugee population has become much more heterogeneous, a factor that may affect the ability to culturally tailor the provision of healthcare, whether in the form of health assessments or continuing healthcare, if this trend persists.

BACKGROUND

Cross-cultural medical encounters between refugees/asylees and healthcare providers that occur during health assessments and/or continuing healthcare visits were the focus of this pilot study, because they constitute a major component in the overall quality of healthcare delivery.

Table 1: Refugee arrivals in Alaska by country of origin, 2000 to 2008

Country of Origin	2000	2001	2002	2003	2004	2005	2006	2007	2008	Total
Former USSR	7	39	18	24	28	13	16	30	15	190
Laos					14	65				79
Yugoslavia	4	15	1	4						24
Sudan									16	16
Congo									10	10
Togo									8	8
Vietnam	2						4			6
Cuba							4			4
Iran		1				2				3
Iraq									2	2
Ethiopia									1	1
Total	**13**	**55**	**19**	**28**	**42**	**80**	**24**	**30**	**52**	**343**

Source: Office of Refugee Resettlement 2009b

Considering the global nature of refugee issues, the health of refugees and asylees is an international concern due to the dire situations of many camps and the conditions of diaspora. Only a handful of developed nations have refugee resettlement programs, and refugee policies that determine access and delivery of healthcare vary depending on location. Nevertheless, a common thread is the diverse ethnic composition of refugee communities in the U.S. and elsewhere, which is reflected in the published literature that addresses refugee health needs, provider-patient interactions, and access to and utilization of healthcare systems. Consequently, the provision of healthcare to refugees is an interdisciplinary area of concern and not exclusively reserved to anthropological inquiry.

Work on cross-cultural medical encounters has been done primarily by the medical establishment, with contributions by social and behavioral scientists. Despite different angles of investigation, the predominant barriers and challenges found in the literature are associated with language and communication (Manderson and Allotey 2003; Miller Lewin 2004; Murray and Skull 2005; Stephenson 1995), availability and quality of interpretation services (Bischoff et al. 2003; Burnett and Gebremikael 2005), differential cultural understandings of health/disease and valid treatments and expectations (Bischoff et al. 2003; Carroll et al. 2007; Koehn 2005; Lawrence and Kearns 2005; Murray and Skull 2005; Stephenson 1995), cultural and/or religion-based rules for gender relationships (Carroll et al. 2007; Miller Lewin 2004), cost of medical visits (Lawrence and Kearns 2005), and mental health needs due to trauma and socioeconomic factors or stress of resettlement (Dhooper and Tran 1998; Gilgen et al. 2005). Together, these factors impact healthcare provision and delivery.

METHODOLOGY

A qualitative research design was employed to gain an understanding of the perspectives of both sides involved in the medical encounter by addressing the main research question: What are the keys to successful medical encounters between healthcare providers and refugees/asylees in Anchorage? In-depth face-to-face semistructured interviews with both refugees/asylees and healthcare providers served as a primary research method. Basic socioeconomic data were also gathered. In addition, the opportunity arose several times to interview providers in their work environment and refugees in their home environments, which afforded a research perspective that is to some degree grounded in the daily realities of participants. The interview protocols for both groups of participants were based on a critical-interpretive anthropology approach, in which healthcare and disease are understood to have meanings specific to certain ethnic groups and within national and global contexts (Lock and Scheper-Hughes 1996). The refugee interview protocol was piloted to check for appropriateness and clarity of the interview questions, which led to some minor changes in the wording of the questions, although the content remained the same. All interviews were conducted between May and September 2008 and

lasted between thirty and sixty minutes with providers and between thirty minutes and two hours with refugees. Refugees and healthcare providers were only interviewed after they gave written consent on an Institutional Research Board-approved form.

All in-depth interviews were recorded using a digital voice recorder and later transcribed verbatim. Provider interviews were analyzed using the qualitative analysis software ATLAS.ti to identify key themes addressed in the interview questions. Use of ATLAS.ti was determined to be inappropriate for analysis of refugee interviews.

PROVIDER AND REFUGEE FINDINGS

DEMOGRAPHICS

The ten healthcare providers who volunteered to participate in in-depth interviews about their experience in serving refugees ranged in their professional background from nurses (n = 2) at the municipal health department to physicians' assistants (n = 3) at the Anchorage Neighborhood Health Center and physicians (n = 5) at the Anchorage Neighborhood Health Center and Providence Family Medicine. The majority of medical providers interviewed were women (eight out of ten) and fairly homogenous in their ethnic backgrounds (nine Caucasians and one Asian provider). Most providers were middle-aged; average age was forty-four. Providers had an average of fourteen years of medical training, had served refugees for an average of more than five years and primarily saw refugees in their practice on a weekly basis. When asked about recent medical encounters with refugees, most healthcare providers recounted experiences with Hmong or African, such as southern Sudanese, refugees, which corresponds with the refugee demographics in Anchorage and with the origins of refugees interviewed for the pilot study.

Refugee participants can be categorized into two groups: African nationals from southern Sudan (n = 4), Senegal (n = 1) and Togo (n = 1) and Southeast Asians from Laos (n = 2) and Thailand (n = 1). The majority were male (n = 6); the average age was thirty-eight. Except for two, a woman from Thailand and a man from Togo, all participants had lived in other states before moving to Alaska; they were thus secondary migrants. At the time of the interviews, refugees had come to Alaska as recently as three months ago and as long as eight years ago. Two of the Hmong participants had been in the United States for twenty-eight years. Furthermore, the one individual from Senegal was actually a voluntary immigrant but also responded to the interview questions as an informant for a refugee family from Darfur, since he acts as their interpreter at medical appointments. Seven of the study participants spent time in refugee camps before coming to the U.S. Most completed at least elementary school and three of those interviewed had college degrees before entering the U.S. After coming to the U.S., five received high-school diplomas; four went on to graduate from college. All of the participants were fluent in conversational English and many spoke several languages, including Nuer, Dinka, Arabic, Hmong, and French. As a result, six of the nine had some interpretation experience in a healthcare setting. The majority (6) had jobs, two were disabled, and one was temporarily unemployed. The employment status is reflected in the type of healthcare coverage, since three had coverage through Medicaid and one through Medicare. Four participants had health insurance through their employers and one temporarily had no healthcare coverage at all. Four were patients at Anchorage Neighborhood Health Center, three sought healthcare at hospitals, one used urgent-care clinics, and one was a patient at a private practice.

KEY THEMES

Both structural and cultural barriers to healthcare were identified. Providers recognized time, indeterminacy of refugee status, missing paperwork, lack of mental health services, and heterogeneity of the refugee population in Anchorage as major structural barriers to providing proper healthcare. On the cultural side, language difficulties, varying interpreter quality, differential understanding of health and illness, and gender issues were mentioned as predominant cultural challenges. Mediating these structural and cultural hurdles are factors such as Medicaid coverage, a good refugee support system in the Anchorage community, partnership and collaboration between community organizations that help refugees resettle, and familiarity of providers with a diverse patient population. The individual characteristics of medical providers in community health organizations further mediated structural and cultural challenges. Cross-cultural empathy, in particular, appears to be a result of prior experience in working with ethnically diverse populations in a variety of settings. Providers identified several needs: more case managers or social workers, better medical histories for the refugees, and more knowledge and educational resources

about various refugee populations. Despite these shortcomings, medical providers highlighted several keys to success in cross-cultural medical encounters:

- Establishing patient-provider relationships based on trust by listening and respecting health beliefs that may differ from the biomedical understanding of the disease process.
- Changing the traditional approach of clinical care focused on the individual to a group approach in which members share the same language and a similar cultural background.
- Maintaining and fostering partnerships and collaboration across agencies that serve refugees.

A further positive aspect that aids in the success of cross-cultural encounters is the perception among providers that refugees deserve their help and that doing so opens a window to the world outside their clinics and exposes them to diversity. When juxtaposing provider findings with findings from in-depth interviews with refugees, there are important areas of agreement. A theme that consistently emerged from provider interviews was how different the Hmong are compared to African refugee patients in two critical healthcare components: the Hmong presented many more mental healthcare needs due to Post Traumatic Stress Disorder (PTSD) and differed significantly in their beliefs about disease cause and treatment from typical American patients and from other refugees. Sudanese refugees were perceived to be more aligned with healthcare providers' biomedical model than Hmong, who were often seen as having nonanatomic, nonphysiological disease explanations. This notion was confirmed by interviews with Hmong refugees, who gave accounts of cultural practices affecting healthcare and the role that traditional remedies and shamans play in medical care (Table 2).

Providers' efforts to empathize and establish trust and rapport with their patients resonated positively with refugee participants, who generally have a positive perception of healthcare providers. Many providers emphasized that listening, having patience, and trying to understand a refugee's perspective and cultural background are crucial components in making healthcare agreeable and effective (Table 3).

Table 2: Juxtaposition of provider and refugee findings part one

Provider Quote	Refugee Quote
Even as I have been here 26 years and I see many Hmong people, they're still pretty mysterious to me.	Hmong Refugee: I don't want to do your CAT scan because traditionally in our culture when I am pregnant my parents won't allow that and my husband. In our beliefs are not allowed, the spirit cannot be contacted while, you know, I am pregnant and so…
I just more recently started to see Sudanese folks and they were just really happy to have a doctor who, it seemed like, I saw one woman and then within one week I have seen like ten of her friends and family members and it just keeps expanding.	Sudanese Refugee: Well, they [doctors] are doing well because I think they got no problems, because they know what they do. I trust them because they know what they do. Whenever they ask me I do tell them what they ask because I know they know what they do.

Table 3: Juxtaposition of provider and refugee findings part two

Provider Quote	Refugee Quote
What really worked well for me is asking them, what is your cultural belief and how can we work within these boundaries and what aren't you willing to talk about and what do you want to talk about.	Hmong refugee: I've been to the Providence Hospital with my last babies. The nurses are really awesome, they are wonderful, the doctors are… culturally I think this city, Anchorage, they are really diverse. They really care about cultures, traditions and they highly respect that. And I am just so amazed.
You know, I think what has worked well for me is if there is an ongoing continually relationship in which you can gain confidence, respect and in that process whether or not they ever perhaps come to understand why I'm doing what I'm doing, you can develop a trust.	West African refugee: I think everything is great, they're, they are kind, they take care of us. Even if we forget appointment they call us to remind us of.

Furthermore, the providers observed that gender tends to be an issue when cultural and/or religious customs set certain rules for interactions between men and women. This corresponds to findings from interviews with participants of African origin, southern Sudanese, and others, who stated that the gender of the provider is more of a concern for Muslims than for Christians. Also, refugee interviews indicated that it was most often a concern for female Muslim patients (Table 4).

There were also areas of disagreement between refugees and healthcare providers. While providers brought up time constraints as a limiting factor, this did not emerge as a problem in refugee interviews. Personal provider attributes were much more significant to refugees, as was the complaint that medical providers often ask too many questions (Table 5). For example, among the Hmong, a close personal relationship with a provider is very important, and touching is seen as essential in diagnosing illness rather than talking and asking a lot of questions (Table 6). Equally affected by cultural expectations is the healthcare provider's assumption that patients should or will raise questions with healthcare providers regarding their illness, diagnosis, and treatment, because a medical provider is regarded by refugees as someone with authoritative knowledge.

Healthcare providers often expressed concerns about the accuracy and reliability of in-person interpretation and the obligation to give up some of their control in a medical encounter to an interpreter. Refugees who had experience interpreting echoed this concern, saying that it is often difficult to find corresponding medical terms in the language spoken by a refugee (Table 7).

One provider described a Hmong patient's reluctance to accept prescription medication. The Hmong appear very concerned about the ingredients in medication, being prescribed the wrong medicine or being overdosed. On the other hand, these issues seemed to be of no concern for the majority of refugees of African origin, who regarded the prescription of medication as the core component for the successful treatment of a health complaint. At the same time, a common theme among African refugees was their general trust and confidence in their healthcare provider's knowledge and skill to address and solve physical ailments, which was less true for Hmong patients (Table 8).

The interview protocol did not address trauma or mental health issues, and thus it was not possible to conclude how much PTSD and depression are perceived as problems among Hmong or other refugees who participated in the in-depth interviews. Nevertheless, mental health certainly appeared to be a concern among providers and worthy of further investigation, as it was mentioned frequently in the context of providing healthcare to Hmong patients. Many refugees mentioned that they only seek medical care if absolutely necessary, which might make providing preventative care a challenge. This seems to be partly due to previous experiences, or lack thereof, that refugee participants had in non-Western healthcare settings, such as hospitals and refugee camps where controlling acute diseases was the priority.

The current pilot study offers some valuable insights into Hmong traditional health beliefs, such as postpartum diet and breastfeeding, with implications for maternal and child healthcare. The traditional Hmong diet dictates that women can only eat certain foods and only drink warm beverages for six weeks after giving birth so that the body can heal itself. Integrating the traditional Hmong diet into hospital menus would make healthcare delivery to Hmong women more culturally sensitive and appropriate. Recommendations to breastfeed, on the other hand, may face opposition among the Hmong due to the apparent belief that breast milk can be lethal to men. Thus, many Hmong women may opt to use formula, since the traditional custom of sleeping in separate quarters and eating alone to safeguard the father of the child are no longer practiced to the same extent as they were in the past. Because many Hmong are still grounded in their cultural traditions and customs despite living in a dominant Western society, shamanism and herbal medicine play important roles in health. Many providers regard Hmong as very different from the typical American or even African patient. This was an unexpected finding but echoed previous research on cross-cultural healthcare involving Hmong patients. For instance, Barrett et al. (1998) found that Hmong patients and their Western medical providers have diverging ideas about health and illness, and it was challenging for providers to understand Hmong health beliefs as they relate to acute versus chronic diseases, prevention, and pain. As in this pilot study, Barrett et al. (1998) reported that many providers mentioned psychological illness and disability as concerns in caring for Hmong patients.

DISCUSSION

This study joins a limited number of other medical anthropological studies that included interviews with

Table 4: Juxtaposition of provider and refugee findings part three

Provider Quote	Refugee Quote
When asked about gender as an issue: Muslim. And that's picked up across the board of all variety of countries.	When asked about gender as an issue: That is a problem with the Muslims. The doctor can be woman or man, no problem. And for my wife.

Table 5: Juxtaposition of provider and refugee findings part four

Provider Quote	Refugee Quote
Advice to other providers: Ask a lot of questions.	But sometimes you know so many questions. You know, some people don't like to ask so many questions, you know. They just kind of don't wanna answer because, you know, for problem of confident [confidentiality] you know.
Advice to other providers: And, you know, try to understand what they are asking. Give them help to ask or have questions if they have any and try to listen.	They [family from Darfur] didn't know that they can ask questions. To them, you just go to the doctor, OK doctor, um, I have a headache. You know and then, so you deal with that and no questions, no whether I should get this whether I should, you know, have a certain diet or I should, no they just, you know, go by what the doctor says. Basically, they did not know the type of question to ask.

Table 6: Juxtaposition of provider and refugee findings part five

Provider Quote	Refugee Quote
People need to be listened to, people need to be touched. I mean this is the thing that people tell me over and over again, say the last doctor didn't listen to me.	Touching you and feeling you when lay there, feeling your head or your stomach then find medicine.

Table 7. Juxtaposition of provider and refugee findings part six

Provider Quote	Refugee Quote
I'll ask them a sentence so then it gets translated as either like one word or twice as long or you know, it's not translated exactly and then it comes back and it's not the answer to the question I asked.	There are so many words that are not native in our language, even how you translate it might be difficult. Here you have to go word by word, you know. I am gonna go shorter maybe just one word, yeah, but maybe doctor might say, oh, oh, how, almost too quick, too short, you know.

Table 8. Juxtaposition of provider and refugee findings part seven

Provider Quote	Refugee Quote
Where we sort of come up against challenges with them [Hmong] is for instance birth control. They're very suspicious about what this pill will cause and I actually had a discussion, since we've run into this a couple times, they tend to have lots and lots and lots of babies and so our first question is you know, do you wanna have these babies and then so why? And so one of the families that I'm just getting to know I said, what is your cultural feeling about birth control. And it was well we don't know what that pill is gonna do. Vitamins, same thing. Just the fact that it's a pill they have to swallow.	Hmong refugee: I still concerned about the medication that I taking every day because, well this kind medication is not nature, it's not from the nature like my ancestors use and this one, this is chemical medication. It's from factory. Sudanese refugee: What I like is I went to emergency and they give me the medicine. I feel good about that 'cause most of the doctors are good people, nice too.

both healthcare providers and refugee patients (Koehn 2005; Lawrence and Kearns 2005; Miller Lewin 2004; Stephenson 1995; Suurmond and Seeleman 2006). Similar to findings from previously published work on refugee healthcare, this study identified cultural challenges such as the impact of language dissonance on provider-patient communication, the importance of quality interpretation through professional rather than lay interpreters, gender concordance between provider and patient, prevention as an often alien concept, and cultural differences in the understandings of health and illness (Bischoff et al. 2003; Carroll et al. 2007; Kang et al. 1998; Murray and Skull 2005; Stephenson 1995; Wissink et al. 2005).

This study shows that patient-provider discordance in explanatory models of medicine varies between ethnic and cultural groups, since Hmong patients were more frequently mentioned in this context than African patients. This became evident in providers' statements that Hmong disease explanations often do not conform to their own biomedical models. Furthermore, interviewed refugees more often recounted seeking medical care for acute or chronic ailments as opposed to preventive care. This was a common finding in the reviewed literature and may be due to previous non-U.S. health care experiences where acute health concerns outweighed prevention due to necessity (Kang et al. 1998; Miller Lewin 2004).

Providers often cited untrained family, friends, and community members as inappropriate interpreters even though they may be able to provide cultural interpretation. The literature reviewed does not specifically address the use of phone interpretation in cross-cultural medical encounters, but providers interviewed for this exploratory study seemed to prefer it over lay interpreters. However, the quality of in-person interpretation will hopefully improve in the near future with the inception of a newly formed language center in Anchorage through the Alaska Immigration Justice Project (2009), whose goal it is to certify interpreters for the court system as well as for health care and social service organizations. Although several studies cite preference of female patients for female providers as a major barrier to cross-cultural communication, it does not appear to be a major concern of providers or refugees in this study. As the literature shows, in cases where it does emerge as a problem, it usually involves Muslim patients, such as Somali women, who because of religious reasons prefer to be seen by female providers (Carroll et al. 2007; Miller Lewin 2004; Wissink et al. 2005).

On a macro level, literature points to structural barriers such as bureaucracy and limited financial resources, refugee's socioeconomic issues related to income and employment, healthcare providers' lack of cultural competency, cost of healthcare, and incomplete health records (Burke 2007; Lawrence and Kerns 2005; Murray and Skull 2005). Findings from the present study do indicate that healthcare provision is negatively impacted by time allocated for medical visits; however, this issue is not reported as a significant challenge in the literature. Providers in Anchorage do not have adequate time to prepare for visits, educate patients, or address mental health issues. Providers may not know that a patient is a refugee until the patient walks into the room. Furthermore, healthcare providers did not consider socioeconomic and political issues to be a barrier to providing medical care to refugees, mainly because they considered Medicaid eligibility, a sound refugee support system through various refugee groups, and good collaboration between agencies involved in refugee resettlement as mediating factors. Refugees who participated in this study did not appear to be significantly concerned about having to pay for medical visits, since most of them had Medicaid coverage or insurance through employment. Much like Adair et al. (1999) found among Somali refugees, neither transportation nor location appeared to hinder access to healthcare among the refugees in the Anchorage study. Providers showed a great degree of cross-cultural empathy, likely due to the fact that many had prior experience and training with ethnically diverse populations. Medical providers identified better medical histories and records management as well as better access to mental health resources, more social work support, and educational resources as areas in need of improvement.

What appears to be a special challenge for healthcare providers in Anchorage is the composition of the refugee population, which is smaller than in other resettlement states but has also become more heterogeneous recently (see Table 2), thereby making it more difficult to be knowledgeable about their patients' diverse cultural backgrounds. However, local providers in Anchorage serve a diverse patient population in general, which may make them better prepared than their counterparts elsewhere when encountering diversity. Koehn and Swick (2006) suggest transnational competence (TC) as a tool to help providers in overcoming the challenge of a culturally diverse patient population. Training in TC focuses on five skill sets: analytic (ethnocultural and sociopolitical analysis), emotional (respect of traditional practices),

creative (integration of biomedical and ethnocultural explanatory models), communicative (facilitation of an open dialogue), and functional (establishment of close interpersonal relationships). Proficiency in these skills gives providers competence in working with patients who differ ethnoculturally and socially from themselves to achieve positive health outcomes.

The issue of mental health of refugees who have experienced violence, rape, and forced migration is well documented in the literature on refugee healthcare (e.g., Barrett et al. 1998; Bischoff et al. 2003; Burnett and Gebremikael 2005; Dhooper and Tran 1998; Gilgen et al. 2005; Koehn 2005; Lawrence and Kerns 2005). This issue also emerged in the Anchorage study; providers attributed the problem to an overall lack of mental health services and identified it as a particular concern in caring for Hmong patients due to an anecdotally high prevalence of PTSD and depression in this refugee population. As Dhooper and Tran report (cited in Kinzie et al. 1990 and Mollica et al. 1987), between 50% and 80% of Cambodian, Vietnamese, Laotian Hmong, and Afghan refugees in the United States suffer from PTSD. However, there seems to be a lack of information on Hmong perceptions of mental health and whether PTSD and depression are perceived as pressing health issues by the Hmong, especially since this population often presents with physical symptoms in response to psychological distress. Future studies should focus on mental health conditions and needs, perceived and actual, among different refugee populations and on how mental health care can be incorporated into a comprehensive approach to healthcare delivery.

Most relevant literature in refugee healthcare tends to focus on barriers and challenges rather than helpful factors and structural and provider-driven strategies that have proven successful in delivering healthcare to refugee patients. Keys to success in cross-cultural medical encounters that have been identified as helpful for healthcare providers are establishing trust, listening, respecting alternate health beliefs, moving from an individual-centered to a group-centered approach to care, and partnership and collaboration across agencies that serve refugees.

CONCLUSION

This study addressed barriers and challenges as well as successful strategies for providing cross-cultural healthcare to refugee patients in Anchorage. As Alaska establishes itself as a refugee resettlement state under the coordination of the Refugee Assistance and Immigration Services (RAIS) program, healthcare providers in primary care organizations and other local health facilities are poised to encounter increasing numbers of refugees with diverse ethnic and cultural backgrounds. The findings presented here can help to make healthcare services more responsive to the needs of a culturally diverse refugee population. Structural and operational limitations often restrict healthcare providers' ability and flexibility in providing proper care to refugee patients. These structural challenges are often exacerbated by cultural and linguistic differences that arise in the provider-patient encounter. Such challenges should be addressed on both provider and organizational levels.

As the first study of its kind in Alaska, this research established a baseline for future studies on refugee healthcare despite some limitations, such as the potential generalizability of its findings to refugee populations in Alaska as a whole. These findings are not necessarily applicable to the healthcare experiences of voluntary legal or illegal immigrants, as they may encounter different circumstances. The study relied on a convenience sample for both providers and refugee patients and had refugee eligibility criteria that excluded participants without conversational English skills; this resulted in a limited pool of potential participants. As a result, the findings are based on the perspectives shared by fairly experienced and empathetic providers as well as educated refugees from a limited number of cultural groups. The results are thus likely more representative of refugees who have lived in the United States for several years than of new arrivals, who may face greater challenges. Nevertheless, this pilot study offers rich insight on challenges and has identified several keys to success for more productive cross-cultural medical encounters. Subsequent studies built on lessons learned here should focus on mental and preventative healthcare, include more refugees who are not yet proficient in English, and consider analysis that matches refugee responses with those of their healthcare providers to facilitate more focused comparisons.

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