

Cross-Cultural “Allies” in Immigrant Community Practice:

Roles of foreign-trained former Montagnard health professionals

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Abstract

This pilot case study describes foreign-trained former Montagnard refugee physicians' practice experiences in Vietnam and their current community health worker and "ally" roles within the Montagnard refugee community. It highlights key features that facilitate cross-culturally responsive health care. We interviewed five Vietnam-trained former Montagnard refugee physicians using an open-ended interview format during March, 2012. We used content analysis procedures to identify key themes characterizing Montagnard physicians' former and current practice experiences and emphasizing the roles they currently play in their new homeland. Montagnard physicians were fighting infectious diseases in homeland Vietnamese communities. Since coming to the U.S., Montagnard physicians have reoriented their competencies to fit within a community health workers model, and have shifted practice to fighting chronic disease in this refugee community. Tasks now include describing and contextualizing unique characteristics of the Montagnard languages and cultures to outside constituents. They become cross-cultural allies to the U.S. health care and facilitate individuals' medical adherence with mainstream physicians' orders. They ensure accuracy of interpretation of Montagnard patients' medical complaints during a medical visit. Our findings reveal the potential roles that can be ascribed to a cross-cultural ally and can be built into practice to fulfill the Montagnard community's unmet health needs: oral historian, mediator, facilitator/negotiator, quality assurer, psychosocial confidant, and health advocate.

Keywords: *Foreign-trained medical graduates; cross-cultural allies; community health workers; Montagnard refugees*

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I. Introduction

Use of the Community Health Workers (CHWs) model to improve community health has existed for more than a half century (World Health Organization, 2007). This model involves the dynamic use of paraprofessionals to “assist individuals and communities to adopt healthy behaviors” through community outreach and implementation of health interventions (U.S. Department of Labor, 2012). CHWs are the members and representatives of underserved or marginalized communities and “serve as connectors” between formal health care systems and health care consumers from the communities (Witmer, 1995, p. 1055). The term CHWs is often used interchangeably with lay health advisors, natural helpers, lay health workers, community health advisors, promotoras and peer outreach workers in the field (Ayala et al., 2010). Despite controversies, research clearly documents the effectiveness of CHWs in promoting health among low-income and hard-to-reach population groups (Viswanathan et al., 2010). A systematic review of published literature from 1980 to 2007 revealed that the duties of lay health advisors and their positions within community-based interventions to reduce health disparities had effectively reduced cardiovascular risks, increased health knowledge, and facilitated behavioral changes (Fleury et al., 2009). CHWs have been instrumental in bringing about favorable changes in participants’ life styles and physiological measures, and reduced utilization of unnecessary diabetic health care among diabetes patients (Brownstein et al., 2007). Similarly, CHWs played significantly positive roles in the improvement of medical compliance (e.g., helping clients follow through with medical appointments and adhere to medications) and thus reduced medical expenditures among hypertension patients (2007).

The CHWs model has been tailored and widely adopted among immigrant communities. In Latino/Hispanic immigrant communities, the model was used to disseminate health information, collect health data, provide health advice, promote navigating health resources, and advocate for community members (Rhodes et al., 2007). This model has demonstrated effectiveness in alleviating a broad range of health concerns including chronic diseases management, injury prevention, cancer screening, prenatal care, health care access, health behavior changes, and control of infectious diseases (Ayala et al., 2010). Among Asian immigrants’ communities, CHWs demonstrated their successful experiences of working with Korean women to increase their breast cancer awareness and screening adherence; with Chinese Americans to improve their awareness of Hepatitis B; and with Vietnamese women to prevent cervical cancer (Han et al., 2008; Taylor et al., 2009, 2010). One example is to compare the effectiveness between media-based education only and media-based education combined with lay health worker outreach to increase cervical cancer screening rate among Vietnamese American women. A total of 1,005 Vietnamese women participated during a three-year period. The findings indicated that with the lay health workers’

engagement, the participants were more likely to take a Papanicolaou test (Mock et al., 2007). However, current literature also stated that the utilization of CHWs in Asian immigrants' communities is relatively rare (Fleury et al., 2009; Mock et al., 2007).

Our study primarily focused on identifying the strategies by which human resources within the community, in this case, foreign trained former medical doctors employ the CHWs framework to address important health related issues plaguing a specific Southeast Asian population, the Montagnard refugee community. The community has been characterized as hard-to-reach, deprived, and underserved. Montagnards are indigenous minorities originating from the highlands of Vietnam. A majority of its first generation resettled in the U.S. was farmers in Vietnam and with very low literacy levels. They speak tribal languages such as Jarai, Rhade, Bunong, Bahnar, Mngong, and Koho. Three main waves of Montagnard refugees arrived in North Carolina (NC) – mid 1980s, early 1990s, and early 2000 with family reunification following each wave. On average, from January 2003 to March 2008, each year, more than 440 Montagnard refugees were mostly resettled in Greensboro, Charlotte, and Raleigh, NC (NC State Refugee Office, 2009). Approximately 10,000 Montagnards live in the Piedmont Triad area, NC. Guilford County has more than 5,000 Montagnards. NC is the home of the largest Montagnard community outside of Vietnam (Center for New North Carolinians, 2012). Our preliminary research with this population showed that the Montagnard community was constantly challenged by being culturally isolated, health illiterate, unemployed, uninsured/underinsured, and financially disadvantaged, having poor nutrition, and experiencing diabetes and hypertension. We also discovered that some individuals were acting as cross-cultural workers or allies and have been instrumental in responding to some of the concerns and questions raised around health and disease management. In order to better understand the roles and impact on community practice of these individuals in health-related issues, we conducted in-depth interviews with a small group of former Montagnard refugee physicians, who were trained in Vietnam but have ceased practicing in this field upon arrival in the U.S. The purpose of this case study was to: (1) describe foreign-trained former Montagnard refugee physicians' practice experiences in Vietnam, (2) discuss their current community practice and cross cultural "ally" roles within the Montagnard refugee community, and (3) identify key features that facilitate cross-culturally responsive health care.

II. Methods

This pilot case study consisted of a small group of culture-sharing and geographically bounded individuals (Creswell, 2007). We used this strategy to help gather a deeper understanding of the complexity of what constitutes health and how it is handled as a community transitions from one cultural environment to another. It offers an opportunity to gather rich contextual information and interpretations of important events and relationships.

Sample

Five Vietnam-trained former Montagnard physicians currently living in NC were recruited through purposive sampling based on the following criteria: completed medical training in Vietnam but neither being trained nor certified in the U.S.; left their profession for more than five years; first entered the U.S. with a refugee's status; and proficiency to communicate in English without the use of an interpreter. The participants were either introduced to us by community partners or encountered at social gatherings in the community. The study was approved by the Institutional Review Board at the Southern Illinois University at Edwardsville, University of North Carolina Greensboro, and North Carolina Agricultural & Technical State University, and we obtained written consent from all participants.

Data collection

The research team consisted of four academic researchers and one community partner. We conducted face-to-face semi-structured English language interviews in either participants' home or a public setting in March, 2012, with five participants who met our inclusion criteria. Each interview was digitally recorded and lasted on average for more than 2 hours. A semi-structured interview guide was used, which included four areas of questioning: (1) medical training and related experiences in their country of origin, (2) perspectives on health status of their community in the U.S., (3) comparison of Vietnam and U.S. based health care systems, and (4) perceptions of strategies to ensure culturally responsive health care. Participants shared their stories and insights as well as provided additional supporting evidence, such as free writings and documents. Each participant received \$40 as compensation for their time.

Data analysis

Transcripts, notes, and documents were analyzed using a content analysis approach within which thematic and within-case analysis were conducted (Creswell, 2007). Data were examined both respectively and comparatively to identify the key sentiments about health of the Montagnard community and gather their perspective on taking on and advancing a CHW role in their community. We use the following pseudonyms to refer to our participants in the results section: Dung, Cam, Hien, Minh, and Bao.

III. Results

Our case includes two females, Dung and Cam, and three males, Hien, Minh, and Bao. They were in their mid-40s and 50s, and resettled in the U.S. for an average of 10 years. They received their medical training in Vietnam in the late 80s and 90s. However, they left their profession after they came to the U.S. Besides English and Vietnamese, these former Montagnard physicians mastered at least two tribal languages. Only Minh and Bao were currently full-time employed as factory workers.

Historical accounts of disease transition

In Vietnam, these former Montagnard physicians mainly treated patients with malaria, poor nutrition, as well as other infectious diseases that resulted from poor sanitation and environmental hazards, in the jungles of Vietnam, and in Cambodia refugee camps. Hien recounted that it was common to see Montagnards living in villages with malaria. In his capacity as Assistant Director in a district hospital, he would send a medical team to the village to bring them medicine. He also worked for five months with the United Nations in Cambodia. He dealt with malaria as well as other conditions from post-war environmental hazards:

Because after they have war, war, some weapon[s] [were] blown up, they have bad weather. Some of Vietnamese, they use the chemical to put in the river stream. And they have bad water. And when I live in the camp, a lot of people, they have sore throat [...] and with some people, they have sick history from Vietnam like kidney, they have headache, backache, malaria, some people with [...] they have, a lot of things, I use medicine to give to them. They feel fine. Sometimes, because we have situation by drink[ing] water, dirty water, use dirty water [...] we just use river, stream, we take dirty water to use and cook. Some people, they feel hurt [...]

Bao recalled encountering malaria patients who were often too late in the disease progression to be treated, and who were carrying their resultant liver damages for a lifetime:

The most people, they got like malaria. They live in the jungle [...] they don't have, no medicine, no doctor, no nothing, you know. And when I go see the patients, you know after they [...] being about 2 or 3 month, you know, malaria [...] after they, treatment is fine, [but] the most people, they have gotten to, the liver problem.

He shared his one-week experience of delivering health information to the Montagnards staying in the jungles. He taught them how to use clean water and how to take medicine.

After coming to the U.S., these Montagnard physicians agreed that malaria was no longer a major health threat they encountered. Instead, the Montagnard community is now being challenged by chronic health conditions or diseases, such as overweight, hypertension, and cardiovascular conditions. Dung commented that the community had little knowledge about nutrition. He felt they ate too much meat while they should have eaten more vegetables and fruits, to have a balanced meal. She added that more and more Montagnard kids were becoming obese, and talked about the evident increase in the body size of the second Montagnard generation compared to the first Montagnard generation. Hien thought that this was related to both of their diet styles and lack of physical activity. He said:

Almost the problem with the Montagnard people right now, [as] they stay in America, I think [they] buy food, gain weight, and they have high blood pressure. And then they [have] heart attack [...] because the meat, [that] they compare with the vegetable, [is] cheaper more than vegetable [...] sometimes, they eat only meat with rice. They don't [...] have a lot [of] education. Because they didn't know good food for them to have, that is thinking meat is good to eat. They just eat [...] when they eat [...] they didn't exercise a lot. Exercise, they didn't take exercise too much. In Vietnam [...] they eat a little bit meat but they go to work outside. But in the America, they work inside, in the manufacturing. A lot time, [they] work inside, they cannot go outside. That is they don't have a lot sweat. If they got sweat, that is something they have been improving. Something like toxicity inside and they get out.

Minh gave an example of a Montagnard family that he knew, that had shifted their diet and was "addicted" to fast food:

A family is not so far from here. [When] they were in Vietnam, they were so poor. You know, rice, even they didn't have rice to eat every day. Yeah, they struggle with their food every day. When they came here, they love pizza, I don't know [...] and every day they eat pizza and you know like drink coke, sprite [...] they just like them, and eat every day, now her children, a problem, obesity. Yeah, and not just obesity, some other things happen too [...] she's been here more than 10 years I think [and in 10 years, all these serious problems happened. [...] they just see what they can eat. What people can eat over here, they can eat. Just eat it, they don't think, you eat too much bad for your health, or whatever, they don't think. [Hamburgers] that is easy, easy to, you know, to eat. They don't have time. They don't spend a lot of time cooking.

Mediation of unique cultural characteristics of Montagnards to outside constituents

Dung particularly emphasized the importance of attention to differences among ethnic groups in her practice as a medical practitioner in Vietnam. She said that she used to treat both Vietnamese and Montagnards, and she was constantly reminded of how differently these two groups coped with diseases. In her opinion, Montagnards have a stronger immunity to fight infectious diseases than the Vietnamese. Vietnamese have more tolerance for conditions such as dehydration. She provided some narratives in support of this:

You have to know where they come from [...] the ways they answer you are different. For Montagnards, you need to know which areas [they come from] because of malaria. Even hypertension medication can treat different race differently. I look at the skin [race] [...] I know whether this medication is effective. Montagnard women look much older because they don't take care of themselves [...] not eat right. They don't have birth certificate. They don't know [their] age [...] Montagnards are so afraid of surgery. They get surgery, they die. They have hemorrhage, anemia, they cannot stop bleeding. They need good Vitamins, food before surgery. Also, they are afraid of surgery so they are not ready to fight. They die [not mentally prepared]. A man had surgery died. Another woman, I was the interpreter [...] they said yes to surgery. She had the surgery. She died. They [American physicians] don't know the physical differences. Montagnards, they don't know [how] to express their sickness easily. If they said [they are in] pain, it will be very serious. A man felt painful with his stomach. The man died shortly because of the internal bleeding. If Montagnards complain, please treat them quickly. They don't speak up what they need [...] [American] physicians don't understand us. We don't know how to express our symptoms.

Bao felt that this particular disposition helped him pay attention to the cultural ways of information giving and gathering. He specified, "You have to ask [them] the same as police ask criminals...you find the word to make them to tell you". Cam brought up a similar example, to explain how cultural misunderstanding leads to misdiagnosis. He recounted how a Montagnard female patient had chronic internal bleeding for almost three years. She went to see a doctor for several times but she did not feel confident enough to describe her symptoms to her doctor. Until Cam and two Montagnard lay community health workers noticed this and urged her to go to the hospital for one more time, she never got diagnosed and treated correctly. Because of the misdiagnosis, the physical, psychological, and financial burden added to this patient's family was considerable. With Cam and others' encouragement and accompaniment, her problem was finally resolved. Cam said that it was such a big relief of the family.

Moreover, the participants pointed out the importance of religion and belief that health is God's will in Montagnard people's health. In Vietnam, Cam indicated:

Living in the village [...] see a lot of problem[s] [...] most of the [...] before we meeting the doctor before, most of my people, no education, now we know about cause, we learn, the American know about cause, before, we believe in sin, we believe everything, you know, sick, we don't go to hospital, like my grandmother, she was having diarrhea, just go out and vomiting, after one night, one day, she passed away. They don't know about [...] like the medicine and [...] [they don't go to the hospital, because] they thought [...] that's one, some sin, they just ask for not kindness, Lord, can take them out, they don't think about go to the hospital, for a lot of people, they sick, they just get, get better by themselves, you know. Not thought about medicine, yeah, that's the first reason.

Bao felt frustrated by how Montagnards' health was interrupted by their misinterpretation of the Bible. Bao explained:

The most people over here [America] [...] because they never been to school, they don't know. They said, believe in God, some people, they go [to church] four times a week [...] and in the church, who teach them, some of them, they have license, it's fine, They understand. They follow the rule. Some people, they don't have no license for it. They just teach, make money...they do [teach the Bible] in their house. They said, if you believe in God, they said, you have to give like...money to whoever teach you, so God is going to bless you [...] Some [Montagnard] families, they just pray, they don't take [the patient] to the hospital. You know, when you, the children, they

are really sick, then you take to the hospital, it's too late [...] God, he give[s] everything, you know. The thing is if you want to be your own, you have to learn, you have to study, you have to work hard.

Facilitation and negotiation of individuals' medical adherence

Dung started with a tragic story to explain her role and significance in managing community members' medication use:

A man across the street is about 40 years old died suddenly in the morning. He had a heart attack. You always have to monitor your health and take medication regularly [...] OTC [medication] can cause death. They [Montagnards] don't know the side effects. Taking too much, you may cause death [...] Most time, Montagnards need interpreter when they go to [see] the doctor. Instructions on the bottle need to write [in] Montagnard language [...] [I take them to see the doctor], first I explain to them [how to use the medication] before I leave.

These Montagnard physicians talked about being continuously approached by their people for medical advice in venues such as their churches and homes. They described the problem of medical non-compliance and placed it as a serious concern in the Montagnard community. Hien described the different attitudes toward medication and discussed some of the behaviors that affected outcomes among the Montagnard people:

[Many Montagnards coming to me and ask for medical advice.] I go to church and some people, I help them, I explain for them [...] they [feel] comfortable if I explain for them...to know about the medical...with their health problems, and I give for them some information, medical information [...] Because they take some medicine [the American physicians prescribed], because of high dose [for them], high dose like [...] they use, they say strong medicine, but not strong [it's normal for Americans.] [...] they compare, yes, they use it, they always get sick after they use the medicine. They have stomachache, they have something to make them to want to vomit [...] a lot thing, no good for them body. If they stop to use it, they feel better. They say [that] if I go to the doctor, I have more bad the health [...] they have more [bad] not good, that is [what] they say about America medicine [...] very strong. But I explain a lot [...] Some people they know [how to use the medicine], some people they don't [...] my niece have two children, sometime they [get a] cold, like a cold, use medicine, they don't know how much to use that sometime, what the medicine to use and what the medicine to use every day. They don't know that. I tell for her...sometime some people they very [...] use medicine to make more doses for them, for her children. Like one family, they want to her children quickly fine, quickly well and they give for the children take more medicine and after that [she] bring, [she] brought her children [to] go to emergency [room].

Bao described how he was “babysitting” a Montagnard individual to complete his medical visit:

He [has] been sick for three weeks [...] he won't go to hospital. He don't [know] where the hospital [is] [...] they said, they don't speak English [...] I said, ok. I am going to take you on Saturday or Sunday. What they call [...] oh, primary care. Take him go there [...] they give the paper, he don't know how to write his name. I said, ok, I am going to write it for you [...] and I talk to the doctor. The doctor said ok, he is going to be fine. And they give the prescription [...] and he said, where are we going next? We are going to get the medicine, I said. He said, why we don't get over here? I said, the doctor don't have medicine over here. All the medicine, they keep it in the pharmacy, Walgreen or somewhere else. I said, we are going to get over there. I said, do you have money? He said, for what? I said, for medicine. You have to pay for that [...] then we get there and pick it up, you know. And I told him how to use it. I said, take this one, you use before lunch, before meal,

this after meal, you have to use every day. I said, when you use it, you don't use alcohol. Then he said, ok...you know the problem with them, they ask me, said, why we don't get the medicine like from Walgreen and we have to get the prescription from the doctor? I said, look, this one is regular medicine, don't work, you just, just help you little bit. But doesn't work like, he said, not good? I said, I didn't say not good. It's good but not work very well like the prescription from the doctor. If you want to get good medicine, you go to see a doctor, they write you, give you prescription. And you go and get good medicine.

Quality assurance in the medical interpretation of patients' complaints

The inaccuracy of medical interpretation is another major concern raised by the participants. Minh described how interpretation can make a significant difference in both diagnosis and treatment:

I think he went back to Vietnam now, I don't know. By the time, he got a problem in stomach but I know how [he] came to the doctor, ask about the questions, finally the doctor diagnose him with mental problem and give him the mental medicine. When he used it, I ask him again, again, and again about his problem, finally I found out he got a problem in his stomach. And I say, no, just different way [...] I say, ok, this is a big problem, it's quite different...your problem is the stomach, it's not the mental problem [...]because he knew I knew a little bit English and he knew me as doctor, he took me to do the interpretation to the doctor [...] I went to the doctor and when he asked questions, I said, ok, this is this and I was translating. His answer was quite different with the first and second time when he went to see the doctor [...]

Bao concurred. His niece got a fever two years ago, and her parents called an interpreter to go to the hospital with them. The interpreter misunderstood the situation. Instead of telling the doctor she had a fever, he interpreted it as her parents burned her. Bao was there, and he corrected him immediately:

No, no, no, it's my family, I know it, they never done like that, why they translate like that, I said, it's wrong [...] completely wrong because the translator translate wrong, you know.

Hien explained that the reason for these incidents happen was mostly because the interpreters did not have a medical background and did not understand medical terminologies. Bao also suggested that physicians and interpreters should use "the regular, the normal language" or plain language for less educated Montagnard patients such as:

Like the kidney problem [...] I said how many time you go to the bathroom? They said, maybe two, maybe three, I said, what color is it, I want to know, what color is it, red or Yellow? They said, red.

IV. Discussion

Montagnard refugees who are Foreign-Trained Medical Graduates from Vietnam have had to redirect their experiences and skills to address unmet health needs in the U.S. based Montagnard community. They have shifted their experiences from fighting infectious disease in their homeland to tackling emergent chronic disease and facilitating/managing medical compliance among their community. They now function as community health workers who manage medical adherence issues and cross-cultural allies who contextualize the cross-cultural

differences among the tribal groups. They interpret and validate the patient complaints, and advocate for care as the population with the U.S. system.

The findings illustrate the multifunctionality of former Montagnard physicians, who despite not being able to practice as U.S. recognized clinicians, are able to function and expand the features typically ascribed to a CHW. What makes the cross-cultural ally designation a compelling one is that these former Montagnard physicians possess Western medical/clinical knowledge and skills with simultaneous cultural expertise from living in both Vietnam and America. As medically trained physicians and oral historian, they have witnessed the changes in lifestyles and health conditions, and recognized the historical and socio-ecological agents that led to these changes among the Montagnard community. They are also conscious of their people's prior health conditions (e.g., water-related infectious diseases such as malaria with its kidney and liver complications), which may be carried over to their new life in the U.S., as well as their low health literacy level, which prohibits their understanding of how to successfully transition to healthy diet and nutritional status within this new environment. Serving as mediators, they work on a mutual understanding and resolving conflicts between Montagnard patients and their American health providers. They are multilingualistic, and they are very familiar with the expressions of Montagnard patients' health complaints and their disease coping mechanism. As Dung urged, "if Montagnards complain, please treat them quickly. They don't speak up what they need". The physicians have proven competent in managing Montagnard patients' comfort levels in order to win their trust and encourage them to provide enough medical information for diagnosis. Cam's story with the bleeding female patient exemplifies the need to build trust and rapport in sensitive and critical health situations. With Cam and two CHWs' attention, this patient finally gained self-confidence to communicate her needs, thereby allowing her to receive medical attention and treatment. Religion plays a strong role in this community's approach to health, and Biblical text is often used to determine the Montagnard individuals' health behaviors. As such, the physicians have acted as "cultural brokers" bridging and reconciling Montagnard community religious convictions in the context of care within American health systems (Love, Gardner, and Legion, 1997). A CHW diabetes intervention found that with CHWs' involvement, and understanding of religious attitudes, participants increased their assertiveness and confidence in asking their health providers questions and requesting diabetes care services (Heisler et al., 2009). Additionally, a good patient-doctor relationship can serve to improve patients' medical adherence: former Montagnard physicians' capacity as a facilitator/negotiator, they encourage and direct Montagnard patients to be communicative and compliant with their medical orders and follow up with their medical appointments. Non-adherence has amounted to sudden death, overdose, and "babysitting" for a medical visit. They represent a point of accessibility that is frequently missing in mainstream health care delivery or that has been ascribed to entities outside the community (Brownstein et al., 2007). Part of culturally responsive care is addressing patient's comfort level with provider. As Hien indicated, Montagnard patients felt comfortable if he explained to them the doctor's orders. This opens the possibility for a more tailored intervention to improve medication compliance. For example, these former physicians could deliver regular reminders to Montagnard patients in order to improve compliance. The Montagnard physicians' concerns about the quality of current medical interpretation/translation services have been echoed in other studies. They witnessed the occurrence of misdiagnosis and mistreatment due to misinterpretation, which can be a common mistake when there is a language barrier. In response to this, Hien has started translating medical terminologies from English into Montagnard tribal languages. Bao also agreed that this may be a unique opportunity for the Montagnard physicians to assist their community in assuring the quality of medical interpretation/translation because of their unique position of medical training and background coupled with a proficiency in speaking multiple languages – English, Vietnamese, and a variety of Montagnard tribal languages. Montagnard tribal languages currently are not available with either phone interpretation services or printed materials.

Beyond these primary roles as CHWs, these former physicians' roles of psychosocial confidant and health advocate should also be considered in case of a need. Both Dung and Minh had experiences of providing

psychosocial support either in person or by phone in Vietnam as well as joined other Montagnard physicians in helping Montagnard patients advocate for themselves and for once they began interacting with the local health provider networks and academic institutions involved in community based health research and service.

Implication for community practice and research

Our study has a significant implication as it highlights the importance of identifying and mobilizing community's own and often hidden assets. These foreign-trained former physicians were hidden in their community, working in the factories and nail salons or being unemployed for many years. Yet, they too are invested in seeing better outcomes among their community. Like many other foreign-trained medical graduates, their prior knowledge, skills, and credentials are not acknowledged in the United States (Skolnik, 2012). Linguistic, cultural, financial, discriminatory, informational, and organizational challenges have significantly prevented them from accessing to American medical training and resuming their previous profession (Dorgan et al., 2009; Kaafarani, 2008; Leon et al., 2008). However, the current calls for a more culturally competent workforce and more minority paraprofessionals, provides ample platform for investments in retraining these individuals. Local community colleges, technical training centers, and universities could begin to establish programs that provide, for example, refresher courses in medical terminology, volunteer opportunities, or apprenticeships for understanding the structure and function of U.S. clinical care and public health sectors by using trainer mentorship models, develop their competencies, advance their current roles as "allies" including becoming cross-cultural trainers for health care providers, and increase their possibility to return to the healthcare workforce. Conversely, this may motivate American health professionals to invest in partnering with Montagnards to offer cross-cultural training to new and upcoming health providers who are likely to be primary and special care givers to this population.

Further research needs to capture the diversity of professional voices (e.g., former trained Montagnard nurses, technicians, CHWs, and other community leaders). This could potentially lend insight on how to improve the representativeness and replicability of current strategies. Additionally it could serve as a strategy to identify other community members who could fulfill the CHWs roles. In practice, community representatives who understand the importance of the hierarchical structure of Montagnard community could help involve a larger pool of constituents (i.e. Montagnard church leaders, political leaders, and community's senior residents) in the health decision-making process and obtain support in any major health promotion activities that may be pursued.

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