

## RESEARCH ARTICLE

### Seeking health care: Marshallese migrants in Hawai'i

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**Objective.** The number of Marshallese migrants has dramatically increased in the US and its territories since the 1986 Compact of Free Association agreement. Their poor health status and patterns of untimely care are considered a great public concern in the host society. This paper examines the health care patterns of Marshallese migrants in Hawai'i and how their specific characteristics and circumstances affect their behaviors when seeking health care services.

**Design.** In-depth interviews were conducted with Marshallese migrants, key informants in the Marshallese community, and health and social service providers in the local community.

**Results.** This study reveals three important patterns of health care seeking behavior among Marshallese migrants. First, Marshallese migrants do not seek health care until they perceive a health crisis, usually indicated by pain. This cultural notion of 'present crisis-oriented health care' governs overall health care behaviors of Marshallese migrants. Second, Marshallese migrants are highly reliant on parochial networks for health care, given the strong mutual trust and the value assigned to interdependency within their culture. Despite many benefits of these networks, heavy dependence on them results in failure to obtain timely care when network resources become inaccessible or unavailable. Last, Marshallese migrants in Hawai'i do not rely on traditional health care practices as much as on the allopathic health care system. Their health care depends heavily on curative and tertiary care and health care assistance in the public sector.

**Conclusion.** Health care seeking behaviors of migrants are shaped by cultural definition of health and health care and macro-social factors such as characteristics of the co-ethnic community and social networks, the health care system, and health policies, in addition to individual's socioeconomic status. These findings have important implications for community health care practices and policies.

**Keywords:** migrant health; health care; culture; social network; Pacific Islanders

#### Introduction

The United States immigration policy and foreign relations have contributed to changes in the influx and composition of immigrant populations. The 1965 Immigration Reform Act resulted in an increase in the number of immigrants and shifted the origins of immigrant streams from Europe to Asia and Latin America. The Compacts of Free Association (COFA) implemented in the late 1980s<sup>1</sup> have

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contributed to recent dramatic growth in migration from Micronesia<sup>2</sup> to the United States and its territories. The majority of Micronesian migrants are from the three nations known collectively as the Freely Associated States (FAS): the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and the Republic of Palau (ROP).

High rates of poverty and inflation and poor public service infrastructure and resources in the FAS (Hawai'i Primary Care Association *et al.* 2002) have pushed many citizens to leave their countries seeking better education, economic opportunity, and medical treatment (United States General Accounting Office (GAO) 2001). Coupled with their geographic proximity, unique social entitlement and benefits endowed by the United States (Greico *et al.* 2003) have been magnetic factors for Micronesian emigration, particularly to three US areas—Guam, the Commonwealth of the Northern Mariana Islands (CNMI), and Hawai'i.

New geographic concentrations of specific minority groups due to changing migration streams have stimulated debate over social and economic impacts of immigration at the community, state, and national levels (Lapinski *et al.* 1997; Rothman & Espenshade 1992). The increased volume of migration from the FAS has intensified debate over the impact of the migrants particularly in the health sphere of the three US areas noted above. The impact cost of providing health care and education to FAS migrants in the three US areas between 1986 (when the Compact was signed) and 2000 was estimated at between \$371 and \$399 million (GAO 2001).<sup>3</sup> Dual epidemics of communicable and chronic diseases (Pobutsky *et al.* 2005) and migration-related characteristics—including the high proportion of FAS migrants requiring medical treatment, a circular migration pattern,<sup>4</sup> and exemption from overseas health examinations before entering the United States—have exacerbated public health concerns and have had an enormous impact on health care systems in the host society (GAO 2001). In particular, the delay in seeking care and the subsequent under-utilization of professional care among FAS migrants, in spite of favorable government policies toward this group, are identified as critical health care issues. However, surprisingly little is known about the health care status of FAS migrants and their health care seeking behaviors in the new cultural and social setting.

Researchers from various disciplines have provided understanding of the patterns and the contributing factors of seeking health care between and among different ethnic and immigrant groups (Ell & Castaneda 1998). The integrated approach focuses on what factors contribute to people's access and use of health care services and what the consequences of their choices are at the individual and community levels (Aday & Andersen 1975; Andersen 1995; Institute of Medicine 2001). This approach provides a comprehensive picture of health care access and utilization by including the individual characteristics and their interactions with variety of contextual variables such as the health care system (including health policy, resources, and organizational characteristics) and the external environment (i.e. physical, political, and economic components) (Andersen 1995). Several early studies paid more attention to the decision-making process of health care utilization. In this approach, seeking health care is viewed as a dynamic social and cultural process (Mechanic 1972). It is focused how the cultural context and beliefs about health and health care (Becker & Maiman 1975; Harwood 1981, Rosenstock *et al.* 1988) and social interaction within lay referrals and social

networks (Mechanic 1972, 1978; Suchman 1965b) are involved in the process of seeking health care services. Both approaches are useful frameworks to understand and explain the different health care patterns among ethnic and immigrant groups.

Following a thorough review of the literature, this study examines the health care patterns of FAS migrants and how their cultural and interactional characteristics and situational factors operate in the context of seeking health care services. Specifically, it focuses on Marshallese migrants in Hawai'i who make up more than 80% of total Marshallese migrants to the United States and who are also proportionally the largest group of FAS migrants coming to Hawai'i for medical reasons (Greico *et al.* 2003). In-depth interviews with Marshallese migrants, key informants in the Marshallese community, and health and social service providers gave detailed information necessary to the understanding of migrants' health care seeking behaviors and health care issues.

## Background

The RMI is a small country (only 70 square miles of land) comprised of 29 coral atolls and five coral islands in the Western Pacific, with a total population of 61,815 (Central Intelligence Agency 2007). Approximately 70% of the population live on two urbanized islands, Majuro and Ebeye (Republic of the Marshall Islands Ministry of Health 2004). Overall, the educational achievement level of the population is low: with high drop-out rates from school due to the high intra-island mobility of parents and families as well as cultural familial expectations, in particular for young women. The RMI is a poor country with an estimated GDP per capita of only \$2,416 in 2004. Its economy depends mainly on assistance from the United States under the COFA agreements, with direct aid accounting for 60% of the national budget (US Central Intelligence Agency 2006).

In spite of 14% of the nation's budget appropriation (US \$15,756,334) to the Ministry of Health in 2004, the RMI suffers from high infant mortality (28.43 deaths/1,000 live births in 2006 estimation) and relatively low life expectancy (70.31 years in 2006 estimation). The high prevalence of both communicable and chronic diseases is considered growing health issue in the RMI (Republic of the Marshall Islands Ministry of Health 2004). A change in diet and physical activity, stemming from American dietary colonialism and a shift in livelihood from marine foraging to sedentary occupations have brought on a rapid health transition, including increases in the prevalence of diabetes, obesity, cardiovascular disease, and cancer of various kinds (Pobutsky *et al.* 2005). The islanders also suffer from malnutrition and dietary problems such as vitamin A and iron deficiencies and anemia (Palafox *et al.* 2003). In addition, rates of various forms of radiation-related illnesses such as cancers and thyroid problems continue to increase due to exposure to radiation caused by immediate fallout and resulting contamination from nuclear bomb testing by the United States<sup>5</sup> between 1946 and 1958 (Watkins *et al.* 2006).

The lack of a health care infrastructure<sup>6</sup> and trained health professionals prevent the population from receiving appropriate health care services (Diaz 1997). The shortage of health care resources and the need for medical services, particularly tertiary care, is a significant reason for recent emigration from the RMI to Hawai'i and Guam.<sup>7</sup>

### ***Historical context***

The RMI underwent colonial rule by the Spanish, Germans, and Japanese before the early twentieth century, and became one of the strategically important Trust Territories of the Pacific Islands (TTPI) administered by the United States in 1947. The 1986 COFA agreement with the United States incorporated the RMI as one of the independent FAS. A subsequent amendment, negotiated in 2003, extended the Compact agreement another 20 years; this went into effect in 2004. The two separate but interrelated laws (PL 99-239 & PL 108-188) implemented by the Compacts agreements provide unique legal status for the citizens of the RMI in the US as well as direct financial aid and US defense of the islands. RMI citizens are entitled to enter and exit the United States without a visa or time limit, have special work authorization permits, and receive public benefits, though with some limitations (US GAO 2001). In exchange the RMI grants exclusive military strategic rights to the United States, including continued missile testing at Kwajalein Atoll (Greico *et al.* 2003).

### ***Marshallese in Hawai'i***

According to the 2003 Census of Micronesians, about 3,000 Marshallese live in Hawai'i (Graham 2004). Eighty-nine percent of them migrated to Hawai'i after implementation of the 1986 Compact agreement in pursuit of economic opportunity, education, family reunification, and medical care. These post-Compact migrants are characterized having more females (sex ratio of 0.92 men for every woman) (Greico *et al.* 2003) as well as a young population structure (median age of 22.5 years in 2003) with a high percentage of children (35% are less than 15 years old) (Graham 2004).

Marshallese migrants are located in the lowest socioeconomic brackets in Hawai'i (Graham 2004; Greico *et al.* 2003). Less than half of the Marshallese have completed high school. Only 18% of Marshallese migrants speak English at home in Hawai'i even though English is the official instructional language in the Marshall Islands. Their per capita annual income is \$4,537, significantly lower than the state-wide per capita income of \$30,001. About 49% lived below the federal poverty line in 2003. Only about 30% of these migrants aged 16 or older participate in the labor force in Hawai'i (Greico *et al.* 2003). The majority of employed migrants are concentrated in sales and services sectors such as agriculture, fishing, forestry, or craft occupations. In general, they are low-wage and part-time workers with limited job skills. In addition, there are a very small number of Marshallese health professionals in Hawai'i. There is one Marshallese doctor, only a few nurses and nurse aides, and a few bilingual interpreters in the health care sector (Choi 2006).

Marshallese in Hawai'i maintain strong cultural values and norms (Choi 2006) which may impinge on the process of seeking health care within the host society. Marshallese emphasize harmonious social relationships and communal goals, rather than individual achievement. Lack of approval or acceptance by their family or community is perceived as a significant problem. They place great value in interdependency based on 'sharing' and 'supporting' within extended family. Family members have full responsibility for one another in everyday life. This strong relationship within extended family members is maintained even after migration. This is expressed through remittances and by circular migration, as migrants often return to their home country several times per year (Barringer *et al.* 1993; Greico

2003). Most significant as a force determining the need for care is their unique cultural concept of time. Marshallese give priority to the 'present moment,' and people who are with them in the present. Most Marshallese live in the present, without preparing or planning for future. They do not keep their calendars or pay much attention to 'clock' time. This cultural perception of time is identified as a major challenge in the health care setting as it seems to prevent the successful interaction with the health care community.

### ***Health and health policy***

Marshallese migrants are considered one of the most vulnerable populations in Hawai'i. The 'dual epidemics' of communicable diseases [e.g. Hansen's disease, tuberculosis (TB), measles, sexually transmitted diseases (STDs), hepatitis] and chronic diseases (e.g., diabetes, hypertension, cardio-vascular diseases, cancers, obesity) are identified as critical health concerns for Marshallese migrants (Pobutsky *et al.* 2005). Although accurate statistics for Marshallese migrants as a separate group are not available, state and anecdotal data on Micronesians<sup>8</sup> provide some sense of the health issues of Marshallese in Hawai'i.

According to the Hawai'i State Department of Health (DOH) (2004), about 10% of new cases of TB in Hawai'i and 61 out of 65 new TB cases from the Pacific islands over the past five years came from those born in Micronesia. In addition, 52% of all new Hansen's disease cases diagnosed in Hawai'i were Micronesian (Maruyama & Bomgaars 2002). These incidence rates are disproportionately high, considering that Micronesians comprise less than 1% of the total population of Hawai'i. Moreover, increasing rates of STDs, especially among pregnant women and youths, have been identified as an emerging health concern (Pobutsky *et al.* 2005). Similarly, the prevalence of non-communicable diseases and chronic conditions among Marshallese migrants is equally considered as a significant health concern. The top two reasons for patient visits among Micronesians in Hawai'i are hypertension and diabetes (Pobutsky *et al.* 2005). These health issues of Marshallese migrants in Hawai'i are closely related to the prevalence of communicable and chronic diseases in the RMI and directly relate to their circular migration pattern and the high proportion of migrants (about 10% of all Marshallese migrants) coming to Hawai'i for medical treatment for progressive chronic diseases (Greico *et al.* 2003).

The 1996 federal Welfare Reform Act restricted the eligibility of Marshallese migrants for most federal public benefits in the United States, but the State of Hawai'i decided to continue general and financial assistance to migrants from the FAS. Unlike immigrants who are denied access to public programs for five years following their receipt of an immigrant visa, migrants from the FAS are eligible to apply for most state-funded public benefits in Hawai'i regardless of date of entry into the United States (Hawai'i Primary Health Care Directory 2002). For example, they are eligible for state health insurance assistance programs such as QUEST (Quality care, ensuring Universal access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided)<sup>9</sup> and Medicaid fee-for-service health coverage, as well as housing and Temporary Assistance to Needy Other Families (TANOF), albeit with some restrictions. That is, in spite of their high poverty rate, Marshallese migrants are assured to obtain health insurance from the States. However, despite all open avenues for migrants to access health care, under-

utilization of health care among Marshallese migrants exists. This paper attempts to explore this issue.

### **Methods**

Data collection took place between June 2004 and February 2005 on the island of O'ahu, Hawai'i. Three different groups were interviewed to obtain a comprehensive understanding of health care seeking behaviors and health care issues pertinent to Marshallese migrants in Hawai'i: (1) Marshallese migrant adults; (2) key informants of the Marshallese community—as a simple indication, key informants will be used instead in the rest of the text; and (3) health and social service providers. The major target population for participation in this study were Marshallese migrant adults who were older than 18 years old and who had resided in Hawai'i at least six months but less than six years. Key informants were comprised of pastors and church leaders in the Marshallese community.<sup>10</sup> Health and social service providers included physicians, public health nurses, bilingual staff, outreach workers, program directors in local community health centers, non-profit/non-governmental organizations, and state government, all of whom serve or work with Marshallese migrants. A total of 17 health and social service providers, 10 key informants, and 20 migrants participated in this study.

A purposive snowball sampling method was employed to ensure maximum variation of the participants rather than obtaining a representative sample. First, health and social service providers in the state government programs, working with Marshallese migrants in Hawai'i were identified and interviewed. As a source of contact, these service providers assisted in contacting other service providers and some of the key community informants. These referred service providers and key informants played an important part in identifying and recruiting other key community informants and Marshallese migrants as potential participants. Marshallese migrants with various demographic characteristics and health conditions were referred based on the recruitment guidelines provided by the researcher: adults from 19 to 65 years old; males and females; those who can speak English and those who cannot; the sick and the healthy; those who have experienced the health care system and those who have not; and those who came to Hawai'i for medical treatment and those who came for other reasons (see Appendix A). This method allowed the researcher to document various health care experiences among Marshallese and increase the scope of observational context privileging recently arrived migrants.

The major data collection method for all three groups was a face-to-face, individual in-depth interview. All the interviews were conducted in English by the researcher with the help of a Marshallese bilingual translator based on the need and preference of the interviewee. The interviews took an hour on average and were audio-recorded with the participants' consent. For confidentiality, the names of the interviewees were not retained. In addition, two small focus groups were held, one with key informants and one with service providers, to supplement the individual interviews. The focus group interview with Marshallese migrants was planned but was not held. The key informants advised focusing on individual interviews because Marshallese are not likely to discuss their personal issues in public conversation. Through group discussions, the focus group interviews

provided more complex responses and clarification about the health care issues of Marshallese. Service providers who could not participate in either the individual or small group interviews due to scheduling conflicts were interviewed through email.

Three different semi-structured interview protocols were used for each group to satisfy the specific purposes of the interviews. The interviews with Marshallese migrants focused on changes in their behaviors in seeking health care during the migration process, current patterns in seeking health care, and the decision-making process in seeking health care in the interaction with their family, ethnic community, and the health care delivery system in Hawai'i. The interviews with key informants were designed to explore the overall characteristics of the Marshallese community in Hawai'i, including cultural norms and values, community structures and social ties, and available human and health care resources within the Marshallese community. Interviews with service providers focused on identifying the health and health care-related issues of Marshallese migrants and the challenges that service providers have faced in providing services to migrants.

All the collected interview data were summarized and interviews rich in information about health care issues and experiences were selected for full or partial transcription after reviewing the audio-recorded data several times. The collected data were then analyzed. First, core categories that repeatedly appeared were identified and classified. The transcripts and the summaries of the interview data were reviewed thoroughly to generate consensus codes including: health care, health insurance, health belief, illness, family, culture, language, transportation, support, and community. Each code manifests several sub-codes. In addition, narrative analysis was used to discern patterns in how Marshallese seek health care. Quotes from the transcripts that support major findings were then selected.

## **Findings**

Three major themes emerged from the narratives of the study participants. Health care seeking behavior of Marshallese migrants is: (1) driven by perception of present health crisis; (2) dependent on their parochial networks; and (3) concentrated on allopathic health care and public assistance.

### ***Present crisis-oriented health care***

Marshallese migrants usually seek health care only when they perceive a present health crisis. A 'perceived health crisis,' indicated by the presence and magnitude of pain, is the most significant marker among Marshallese migrants in deciding whether to seek and to continue to use professional health care services. The cultural definition and interpretation of illness as 'discomfort' or 'pain' at the 'present moment' is closely related to their health seeking behaviors. A key informant in the Marshallese community points out:

In their perception, health or wellness means 'no pain' or 'not having discomfort now or today'. . . . Until their pain is unbearable, they do not see a doctor. Remember, their health needs are dictated by pain. When they feel pain, then that is the time that they go to see a doctor.

Migrant interviews clearly show that they do not seek professional health care until they experience a certain level of pain, which was stated as ‘unbearable pain.’ Minor pain is often ignored, and the absence of pain is considered an acceptable level of health. Moreover, Marshallese migrants place high value on the denial or tolerance of physical pain, leading subjects to accept their illness symptoms. They often ignore and tolerate illnesses for a long period of time and do not seek professional health care until the pain becomes unbearable. A bilingual health service provider recalls:

I had a very shocking experience. I helped a Marshallese lady who had a cancer. . . . One day, I took her to the hospital for a follow-up, and her husband accompanied us. I found something wrong in his walk. So I asked him whether he was okay. He said that he was fine. However, I insisted that he have a check-up with a doctor. After we arrived in the hospital, I took him to a doctor. He was asked to take off his shoes and socks. His foot was covered with a cloth patched with herbal plants and tied with a regular plastic tape. When the cloth was removed, there was a big hole in his foot. It was so big. And from the hole, bloody discharges were coming out. The doctor and I were so shocked. He had diabetes. We took him to the ER right away. His three toes were amputated.... You know, Marshallese seem to be OK, but they may not be.

Some illnesses are believed to have supernatural causes. Interviewees often attributed mental illnesses and unfamiliar physical ailments to black magic or having been cursed. Incurable illnesses such as cancer are accepted with a fatalistic attitude. Illness and suffering are often described as inevitable parts of life. These beliefs and attitudes in general prevent migrants from seeking timely professional care. This pattern is much stronger among older people who maintain traditional cultural practices and health beliefs.

‘Present crisis-oriented health care’ is echoed as well in whether or not treatment and care are continued once begun. Most Marshallese migrants reported that they did not continue treatment, pursue follow-up care, or take medication once discomfort, pain, and other symptoms were alleviated. This applies even to those diagnosed with chronic conditions such as hypertension and diabetes. A 55-year-old male interviewee notes:

The doctor prescribed medication. After I took the medicine, I felt much better and didn’t feel sick anymore. The doctor asked me to come back about one week later. But I didn’t go because I had no reason to go. I was already recovered and not sick anymore.

Health service providers confirm that non-compliance of Marshallese patients is a major problem once they enter the health care system. That is, their cultural definition of and response to illness, rather than being based on any sort of medical diagnosis, directs decision making with respect to seeking professional health services.

The cultural definition of health crisis is reflected in seeking of preventive care and early medical intervention. Most Marshallese participants say that they do not need preventive health care because they are ‘healthy’ and ‘not sick’ and do not need to see a doctor as long as they do not have symptomatic pain. This cultural dominance of health beliefs and health care needs is particularly strong among those who are older and from outer islands, where cultural tradition is stronger and the opportunity to receive professional health care is rare. A Marshallese community

health worker addresses a challenge-driven cultural definition of health, coupled with the limited experiences of preventive health care in their homeland:

Screening or regular check-up is a 'foreign concept' for them. There is no concept of preventive care such as regular check-up or screening. In their perception, health or wellness means 'no pain' or 'not having discomfort'. Thus, it is hard to bring them into the screening program for chronic disease, which have long developing period or do not have apparent symptoms or pain. . . . Thus, most of the patients came to the clinics or hospitals at the very late stage of illness.

Even those who are aware of the importance of preventive health care make little use of such services. Many Marshallese migrants have never received a regular check-up or screening except those with a high level of education and those who have had serious medical conditions such as cancer, heart problems, kidney failure and dialysis, and diabetic complications. In particular, migrants with medical conditions disclosed that regular check-ups or screenings were part of the required follow-up for their surgery or treatment and had been strongly encouraged by their doctors, often reinforced through mailed reminders and/or phone calls. This confirms that Marshallese attitudes to health care are governed by perceived threat, fortified by previous experiences of life-threatening health crises. At the same time, this attitude suggests that their treatment-oriented health care behaviors may shift toward a more preventive approach when the perceived crisis is combined with continuous health education and/or encouragement from authority figures such as physicians.

Women's check-ups and screening are another example that a crisis orientation negatively affects seeking preventive health care. Only a few female participants were aware of the importance of women's check-ups and had received them. Some of the interviewed women did not even know what women's check-ups or screening were. A 37-year-old woman says:

Women's check-up? I have never heard about it. What are they? . . . It seems to be important. But I didn't know because nobody told me about it.

Similarly, a 56-year-old woman asks:

Is it important? . . . I have never done it in my life and I had no problem so far. I gave birth to four children and breast-fed all of them. I didn't have any problem. I don't think I need it. Do I need it?

Even those who visit a doctor regularly for treatment or medication for other health problems presented low awareness and low actual practice of women's check-ups and screening. Interviewed women commonly disclosed that they had not received information or encouragement regarding women's health check-ups from their doctor.

In addition to a predisposition toward crisis-oriented health care and a deficit in information and education about women's health issues, cultural reservations toward exposing the female body exacerbate the under-utilization of women's preventive health care for breast examinations, mammograms, and Pap smears. A Marshallese key informant remarks,

In addition to the pain-indicated health care, there is a cultural taboo [against] showing their body for a breast check-up or mammogram or Pap smear. It is not comfortable for

women to show their body even for a medical reason. Sometimes, it is considered as shame.

A 42-year-old woman similarly comments:

I heard the importance of [women's check-ups]. And it may be good. However, I don't want to do those things. I am not comfortable to show my secret parts of my body to someone, even a doctor or a nurse.

In contrast, immunization is least influenced by crisis-oriented health care attitudes. Most interviewed migrants were aware of and had completed their immunizations. Their accounts illustrate that this is partly related to their experience with immunization programs in the Marshall Islands, which have attained a fairly high penetration rate among the population. State of Hawai'i immunization requirements for enrollment in school and free immunization programs for children are also related to high immunization completion rates among Marshallese migrants, particularly school-age children. All the interviewed migrants with school-age children in their family said that one of the first things they did after they came to Hawai'i was to complete TB clearance, immunizations, and the physical examination for their children required by the state for school enrollment. This suggests that regulations enforced by state authorities coupled with familiarity with immunization programs in the Marshall Islands somewhat override the crisis-oriented health care attitude.

Crisis-oriented behaviors and attitudes dominate Marshallese health insurance status. Rather than obtaining health insurance in advance as a means of maintaining health or protecting themselves from the financial consequences of using health care services, Marshallese migrants tend not to seek health insurance coverage until they become symptomatic. Such patterns are clearly demonstrated by comparing the health condition and the time that migrants first obtained health insurance. Among interviewed migrants, those who have or have had a severe illness are more likely to be insured than those who identify themselves as healthy. Those who came to Hawai'i for medical treatment answered that they applied for health insurance as soon as they arrived in Hawai'i. On the other hand, those who migrated for non-medical reasons did not apply for health insurance until they really needed to see a doctor.

The notion of 'present crisis-oriented health care' is key to understanding Marshallese health care behaviors, characterized as delay in seeking care, abbreviated treatment, and under-utilization of professional health care services. These behaviors appear to be rooted in cultural definition of health/illness and cultural value in the 'present moment,' fortified by the social circumstance of limited health care services in their home country.

### ***Parochial network-dependent health care***

As with most new immigrants, Marshallese migrants in Hawai'i are highly dependent on their migrant networks for obtaining health care. Marshallese migrant networks composed of extended family, co-ethnic friends, and fellow church members are ethnically exclusive and homogeneous, strongly bonded, and interdependent based on mutual trust (Choi 2006). The networks reinforce Marshallese cultural norms and

identity, and provide emotional, informational, and instrumental support at the various levels required for new migrants to adapt or assimilate to the new socioeconomic system and cultural environment. This adaptive assistance ranges from the provision of survival necessities, including housing and food, to immediate practical tasks such as obtaining social security numbers, state identification cards, and employment. Furthermore, migrant networks link newcomers to available social and health services such as welfare, QUEST/Medicaid, and employment programs, all of which play critical roles in the accommodation of migrants.

Accounts of all three participant groups reveal that migrant networks play various roles in the process of seeking health care, including the decision to seek care and access to and obtaining medical care. Migrant networks operate as lay referral systems. Family members and authoritative laypersons such as church leaders and Marshallese health professionals within migrant networks provide advice and involve in decision-making process for health care.

As agents for socialization into the formal health care system and critical reservoir of supports, the networks provide information and tangible aids for migrants who need health care. Most migrants disclose they learn about different norms and rules for the new health care setting from their networks and acquire information about where and how to access and obtain health care services available in both the local community and government programs. Moreover, migrants receive various types of tangible aid to obtain actual health care services such as making physician appointments, filling out applications for health services, arranging transportation and translation services, and giving financial support. Such support is particularly salient for newcomers with limited English language skills, given the deficit of Marshallese translators and bilingual health care staff. A 42-year-old woman reflects:

I heard about QUEST from my sister. She has been living in Hawai'i more than 3 years. She speaks English and knows where to go. She helped me to fill out the applications for welfare and QUEST. . . . If I receive a letter from these programs, she tells me what it says. . . . She is the one who always goes with me whenever I have to see a doctor.

Despite its critical contributions to migrants' health care, network dependency has a downside. The decision to seek health care is not often determined by the need of the migrant, but by the opinion or convenience of the network members. A service provider in an immigrant/migrant health program reveals:

We always encourage them [migrants] to take immunization for their protection. We say it is free. Then, first, they look at their sponsors or family members who brought them here. If the sponsor says to take it or seems to be okay with that, then they take it. But if the person says, "No need," or "Later," then they don't. It really depends on what the person says, not what a migrant wants or needs.

In many cases, migrants are led to dead-end situations in obtaining health care when their parochial networks lack the appropriate information and resources or when network support is not available at times of need. The stories of the Marshallese migrants demonstrate that, except in emergencies, the availability of network members' time and resources, rather than the individual's health care needs, often determines the actual utilization of health care services. For example, setting up an appointment with a doctor tends to be determined by the schedules of the relatives

or friends who are going to accompany the new migrant, rather than by the migrant's immediate health care needs. A 46-year-old woman admits:

Sometimes, I feel like I have to see a doctor, but I don't go because my daughter and my son-in-law are busy. If my friend has time, I ask her to go together. But if she cannot, I just wait until they have time to go with me. . . . I don't want to go by myself.

Similarly a 62-year-old man says:

I have missed my appointments with a doctor several times. My grandson usually goes with me to see a doctor. But he is busy sometimes and cannot go with me. Then I miss my appointment. . . . It happens. Without him, I cannot make it because I don't have a ride and cannot communicate with a doctor.

This high dependency on parochial networks in health care is shaped by the cultural virtue of interdependency as well as shortcomings in linguistic and cultural competence in a new environment. Marshallese place a great cultural value on interdependency based on two cultural norms, 'sharing' and 'supporting', within the extended family. The following account from a key informant illustrates such cultural values:

Marshallese culture is based on extended family and support. This is all about it. It came from Marshallese life style. In Marshall Islands, particularly the outer islands, things are rare. Needs are always there. For example, we go fishing. I had a lot of fish today but my friend did not. Then I share it with my friend. I was lucky today, but it doesn't mean that I will be tomorrow. Tomorrow, my friend may get a lot of fish and I may not. Then he will share them with me. We share always. This is who we are. Sharing is important for us.

Interviewed migrants commonly reveal that given cultural virtue of interdependency, extended family who migrated earlier have the full responsibility in every aspect for the new migrants' survival including basic needs such as housing and food, and health care in the new country. Extended family who live in the same household or close by, provide emotional and instrumental support for each other and pool their family resources to meet their needs and to protect each other from adverse health and financial conditions.

Lack of linguistic and cultural skills lead migrants to depend heavily on their networks. The accounts of migrants illustrate that English proficiency determines the level of dependency on the network, roles within the network system, and the extent of access to health services among migrants. Those who have limited English are more likely to depend on their networks by remaining recipients of support in accessing and obtaining health services. In the following translation, a 54-year-old woman describes how her ability to seek health care is circumscribed by her limited English proficiency:

I have lived in Hawai'i for about five years. I usually don't go out by myself. I am afraid I'll get lost. . . . I don't go to see a doctor by myself. Anyway, I don't understand what the doctor says. So, even though I am sick, I would rather wait for somebody who can go with me than go by myself. . . . Sometimes, I miss my appointment with a doctor because nobody can go with me.

By contrast, migrants with English proficiency are less likely to depend on their networks for help in obtaining health care. They usually become major sources of information and providers of instrumental support to others within their networks, as they usually have better access to the formal health care system in Hawai'i. A 41-year-old woman who can speak English describes a very different experience:

I understand what the doctor says. I go to see a doctor whenever I want to. I prefer to go with my husband but he is busy, so I usually go by myself. . . . Oh, I don't need a ride; I can take a bus.

### ***Concentration on allopathic health care and public assistance***

Despite their conservative traditional beliefs regarding health and illness, few Marshallese migrants in Hawai'i tend to rely on traditional health care practices as much as on the allopathic health care system. The majority of Marshallese participants primarily seek health care from the western health care system even though popular home remedies are often used for mild, non-threatening illnesses. Migrants with a chronic illness, in particular, tend to rely exclusively on the western health care system. They rarely use traditional healers and health practitioners with the exception of some elders. Both key informants and migrants explain that this is partly related to limited availability of traditional practices and medicines in Hawai'i, since these are very limited in Hawai'i and have to be obtained from the Marshall Islands via family networks. Relatively weak beliefs about the efficacy of their traditional medicines among Marshallese immigrants also contribute to their low use of the traditional health care practitioners and practices. A key informant explains that this is a natural consequence of selective migration:

Based on their belief on traditional medicine and Western medicine, there is a wide spectrum of health seeking behaviors in the Marshall Islands. People who have strong belief in traditional medicine live mostly in outer islands, while those who believe in Western medicine live in the major islands. One of the important things is that those who do not believe in western medicine do not come to the U.S. for their medical treatment. They'd rather stay. They do not spend thousands of dollars for the treatment that [they] do not believe [in]. Thus, those who migrated to Hawai'i have trust and belief in Western medicine and American doctors.

That is, only those who believe in Western medicine come to Hawai'i for medical treatment, while those who have strong beliefs in traditional medicine stay in their home islands.

Marshallese migrants depend highly on two particular spheres of the health care system in Hawai'i: public assistance including public health insurance such as QUEST/Medicaid and safety net, and curative and tertiary health services. Interviews with both Marshallese migrants and health care providers illustrate that the majority of insured Marshallese migrants are covered by QUEST or Medicaid. A bilingual Marshallese service provider notes,

I am not sure of the exact number of Marshallese covered by QUEST, but it is very high. I think that about 70 to 80 percent of those insured get QUEST. The majority of the people that I know through my work or my personal relations have QUEST.

This relatively high reliance on public assistance for health care is derived from the unique social entitlements of the Marshallese migrants, coupled with their high poverty. Hawai'i state policy, which allows Marshallese and other FAS migrants to receive public health insurance assistance, essentially ensures that Marshallese migrants have a legal foundation to obtain health insurance given the income eligibility. High concentration below the poverty level enables the majority of Marshallese migrants to be eligible for the state health insurance program. Most of the participants show that they live in poverty, but they have or are in the process of obtaining health insurance. The state health insurance assistance program is identified as the only possible option for most Marshallese seeking insurance, and provides a threshold for access to health care regardless of financial difficulty. A 48-year-old man says:

I work in the McDonald's. I work about 40 hours per week. They provide health insurance but I don't get it from them because I have to pay my share to be covered, which I cannot afford to [do]. I have some other things to deal with. My income is not even enough to pay for my rent, food, phone bill, and other things. Also, I have to send some money back home to support my children. See? I don't have any other choice but QUEST.

Marshallese immigrants are more likely to use community health centers and federal or state-funded hospitals rather than private clinics. The Marshallese participants and health care providers point out that accessibility, availability, and affordability are major attractions of public health facilities. They often serve the patients regardless of their ability to pay for care and provide services for free or base fees on a sliding scale as required. These health facilities are also more likely to have culturally competent bilingual and bicultural staff.

As a noticeable feature, Marshallese exhibit high utilization of curative and tertiary services in the health care system. Most interviewed participants have had at least one person in their household who came to Hawai'i for medical treatment of an advanced chronic health condition such as diabetes or its complications, kidney failure, cardiovascular disease, or cancer. Such conditions often involve surgery or long-term care and treatment, requiring them to either stay in or to continuously return to Hawai'i. As a result, they are likely to continue to depend heavily on Hawai'i's health care system. When coupled with the prevalence of infectious diseases, these use patterns quickly appear excessive. Furthermore, the late debut of the Marshallese into the health care system often results in frequent reliance on emergency services. A 42-year-old woman reports:

I came to Hawai'i to have kidney dialysis five years ago because there was no health facility that provided kidney dialysis in the Marshall [Islands]. I regularly received dialysis. But I collapsed several times and had to go to the ER. After all that, I found a donor and transplanted a kidney. I am fine now but I still have to see a doctor on a regular basis for check-up. So I and my husband decided to stay in Hawai'i.

This contributes to the use of treatment-based and more expensive health facilities such as specialist cancer units, cardiac care units, and intensive and emergency care. Such a high level of dependency on the health care system for secondary and tertiary

care presents an interesting contrast to the under-utilization of health services for primary and preventive care.

### **Discussion and Conclusion**

In seeking health care, both individuals and communities adopt certain behaviors that may impede or assist their receipt of timely health care. Various factors are involved in the decision-making process that determines what specific behaviors to adopt in order to obtain health care. Cultural differences affecting the dynamics of the process of seeking health care have far-reaching implications for both practitioners and policy makers, especially when drawing-up and implementing health care programs and policies.

This study highlights that the behaviors associated with seeking health care are the product of the interactions among cultural beliefs and practices regarding health and health care, characteristics of migrant social networks, and state health policy, in addition to individuals' socioeconomic status. Marshallese health care seeking behavior was driven by the notion of 'perceived present health crisis', heavily dependent on parochial networks, and concentrated on allopathic health care system with considerable assistance from the public health care sector.

Willingness to seek health care is often dependent on the definition and interpretation of health and illness (Mechanic 1972), and as such, culture plays an important role in how people define and perceive health and illness (Harwood 1981; Low 1985). In Marshallese culture, illness or health crisis is defined primarily by the presence of pain and discomfort. Many Marshallese are willing simply to deny or put up with evident symptoms of illness. These cultural beliefs and practices concerning health and health care survive the migration process and continue to be applied in their everyday experience in the new social and cultural setting. This cultural perception of health crisis leads to under-utilization of primary and preventive health care, but also a high utilization of curative and tertiary care, and as its consequence, poor health outcomes and high health care costs.

Although cultural attitudes determine health care seeking behaviors, this study illustrates the possibility for reducing cultural impacts on health care. For example, health policy regulations and requirements such as TB clearance, immunization, and school physicals override cultural impacts on health care to some extent. Strong encouragement and education from health care providers can persuade migrants to take part in preventive care programs as well as to seek timely care, especially if they have faced a life-threatening health crisis. This suggests that policy intervention and consistent health education from health care providers about the importance of primary and preventive health care may result in changes to Marshallese health care behaviors.

Parochial networks based on strong mutual trust, close ties, and interdependence are also closely involved in how Marshallese seek health care services. As health care behavior is a culturally and socially learned response (Mechanic 1972), individual responses to health care are shaped by social relationships at the family, social group, and community levels (Suchman 1965a). Marshallese migrant networks play important roles as lay referral systems, socialization agents, and 'social bridges' between the formal health care system and individual migrants, consistent with the previous studies of different ethnic minority and immigrant groups (Alonzo 1986;

Kang *et al.* 1994; Leclere *et al.* 1994; Rogler & Cortes 1993; Suarez *et al.* 1994). These networks also provide migrants, who normally lack cultural and economic capital, with various emotional and tangible instrumental supports. Such support enables migrants to meet their direct and immediate health care needs. On the other hand, heavy dependence on the parochial network shapes a unique health care pattern. Health care of Marshallese migrants tends to be directed by the availability of family or friends rather than by actual health care needs. It often results in migrants failing to obtain timely health care when their relatives are not available to assist them.

Given that social networks are major socializing and liaison agents for migrants, promoting appropriate health care behaviors for primary care and early preventive intervention through migrant networks would be an effective strategy for addressing some of the cultural challenges in obtaining health care. In particular, collaboration with Marshallese church leaders, who are influential figures in the Marshallese social networks, would help health practitioners and policy makers develop more accessible and effective intervention programs, resulting in improving Marshallese health outcomes and lowering overall health care costs. More culturally and linguistically accessible health services should be made available within the community to buffer any possible negative aspects of reduction in network dependency.

Marshallese health care mainly relies on allopathic health care system and assistance from the public sector including public health insurance and safety nets. This study suggests that the friendly state policy toward this population essentially provides the foundation for accessing affordable health care services by reducing potential financial barriers. The provision of safety nets backed by cultural and linguistic competence and a no-refusal policy for patients regardless of ability to pay contributes to diminishing barriers in the quest for health care services.

There are some limitations to this study. This study is based on a relatively small and purposely selected sample. All the experiences of Marshallese may not be explored in spite of exhaustive efforts to encompass various experiences of Marshallese migrants in Hawai'i. In this regard, the generalization of the findings of this exploratory study to the larger population of Marshallese migrants may be attenuated. Furthermore, this study did not establish a causal relationship between possible contributing factors and health care behaviors because it focused on identifying behavioral patterns after migrants have arrived in Hawai'i. Exploring causal relationships requires further investigation.

Despite its shortcomings, this study fills some of the gaps in our knowledge and understanding of health care behaviors among FAS migrants who tend to be highly marginalized within mainstream American society. This study highlights that the behavior of ethnic and migrant groups in seeking health care is not simply a manifestation of socioeconomic status and cultural characteristics, but is due as well to macro-social influences such as characteristics of the co-ethnic community and social networks, the health care system, and health policies. These findings suggest some practical steps that may be taken in encouraging Marshallese migrants to make more effective use of the health care system and may be applied to other marginalized ethnic groups.

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## **Notes**

1. The Compact of Free Association between the United States and the FSM and the RMI went into effect in 1986; the ROP signed in 1994.
2. Geographically, Micronesia includes hundreds of small islands and atolls spread over a large region of the Western Pacific, including the Territory of Guam, the Territory of Wake Island, the CNMI, the FSM, the RMI, the ROP, the Republic of Nauru, and the Republic of Kiribati. However, this paper follows their narrow usage of Micronesia as roughly equivalent to the FAS, which historically constituted the TTPI.
3. The estimated Compact migrant impact was determined by reviewing annual impact estimates for particular sectors such as health, education, and public safety prepared by the governments of Guam, Hawai'i, and the CNMI. When detailed calculations were not available for some years, impact estimates were prorated for that year based on other year's estimates. Guam identified \$180 million in total impact costs and the CNMI's total impact estimate range was \$105 million–\$133 million during the entire Compact period (1986–2000). Hawai'i estimated about \$86 million during the same period (GAO 2001, p. 17 and 37).
4. The circular migration pattern, coupled with the exemption of overseas health examination, for FAS migrants contributes to public health concerns in receiving societies. Many FAS migrants come to the three US areas to treat their advanced illnesses that require surgery as well as regular or long-term medical treatment. A large proportion of them go back to their Islands after their medical treatments are completed. Migrants with communicable diseases, including Hansen's disease, TB, measles, STDs, and hepatitis, can travel without health examinations. For example, the measles epidemic of 2003 in the RMI and the consequential breakout of measles in Hawai'i is a pertinent example of this case. Out of 11 cases of measles among Marshallese reported in Hawai'i, three cases turned out to be imported via air travel from the RMI (Pobutsky *et al.* 2005).
5. As part of its Nuclear Testing Program (NTP), the United States detonated 67 nuclear bombs in the Marshall Islands between 1946 and 1958. Many of the islands are still contaminated and uninhabitable and Marshallese were displaced to other islands.
6. In the RMI, there are only two major health care facilities providing hospital-based services, the Majuro Hospital and Kwajalein Health Center. The Majuro Hospital provides secondary and tertiary medical care. Kwajalein Health Center provides hospital and public health services to the people in the Kwajalein Atoll and the neighboring communities through their outreach activities.
7. The Bureau of Medical Referral provides medical referral services to RMI citizens in collaboration with the Philippines and Hawai'i. The RMI has spent a considerable portion of its annual health expenditures for 'medical referral services.' At the same time, at the individual level, many Marshallese come to Hawai'i and Guam for seeking medical treatment for their developed illnesses.
8. Here, 'Micronesian' is roughly equivalent to 'migrants from the FAS'. Staff at the Hawai'i State DOH note that most Micronesian migrants to Hawai'i are from the FAS, particularly the RMI and FSM. Most of the state health data are provided under the collective label of Micronesians.
9. QUEST was one of the first Section 1115 waiver projects. It was implemented on 1 August 1994, by the State of Hawai'i. It provides medical and behavioral health services through a

competitive managed care delivery system to create efficacy in the Medicaid program and enable the extension of coverage to individuals who would otherwise be without health insurance (State of Hawai'i 2005, p. 6). QUEST has some income and assets restrictions for qualification. In case of income, adults must not have countable family income that is more than 100% FPL; 200% FPL for children under age 19; and 185% FPL for pregnant women. Countable assets should not be more than \$2,000 for a household of one; \$3,000 for a household of two; \$250 for each additional person. Asset limits do not apply to children or to pregnant women for the duration of the pregnancy plus 60 days.

10. Churches are the only and the most pervasive kind of social institution in the Marshallese community in Hawai'i. They have great influence on sustaining family and community life as well as providing their members spiritual guidance and emotional support. Pastors and church leaders are the community leaders, who make major decisions for the community (Choi 2006).

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**Appendix A.** Selected demographic characteristics of interviewees<sup>a</sup>

Interviewed group	Characteristics	Number of participants
Marshallese migrants ( <i>N</i> = 20)	Gender	
	Male	7
	Female	13
	Age	
	19–30	3
	31–40	5
	41–50	7
	51 and older	4
	Marital status	
	Married	14
	Not married	6
	Education	
	Less than high school	12
	High school graduate	8
	Employment	
	Working	6
	Not working	14
	Length of stay in Hawaii <sup>b</sup>	
	Up to five years	17
	More than five years	3
Interviewed language		
English	6	
Marshallese	14	
Health insurance		
Yes	15	
No	5	
Key community informants ( <i>N</i> = 10)	Gender	
	Male	7
	Female	3
	Age	
	35–45	4
	46–65	6
	Education	
	High school graduate	7
	College and above	3
	Length of stay in Hawaii <sup>b</sup>	
Up to five years	4	
More than five years	6	

<sup>a</sup>Health care and service providers participated in this study, but are not included in this table because their demographic information was not available.

<sup>b</sup>Because of the circular migration pattern among Marshallese migrants, length of stay is based on the most recent date they came to Hawai'i to live.

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