Chuukese Migrant Women in Guam: Perceptions of Barriers to Health Care

Margaret Hattori-Uchina

Villanova University

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Dissertation Committee Members:
Linda Carman Copel, PhD, RN, PMHCNS, BC, NCC, CNE, FAPA, Chairperson
Barbara B. Ott, PhD, RN, Co-Chairperson
Nancy Sharts-Hopko, PhD, RN, FAAN, Member
Suzanne Smeltzer, EdD, RN, FAAN, Member
Dedication

I dedicate this dissertation to my family for their never-ending support in the journey to achieve this goal. I am thankful to my parents, Paul and Fermina Hattori for their encouragement and to my mother for her proofreading and editing assistance. To my husband, Katsuyoshi, and children, Marijuana and Angelina; without their love and understanding, I would not have completed this work. To my eight siblings: Anne, Mary, Yvonne, Paul, Stephen, Thomas, Barbara, Robert, and their significant others, my nieces, nephews, and other close family members and friends, who have seen me through the past 7 years: I thank you sincerely for the help with my children, the encouragement, and the cheerleading. It has truly been a family effort to complete this dissertation. I thank you all with much love.
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Abstract

A descriptive qualitative study examined perceived barriers to health care among Chuukese migrant women in Guam and the factors that influenced health-seeking behaviors. Since the Compact of Free Association with the United States was enacted in 1985, there has been a dramatic rise in the numbers of Chuukese migrating to Guam. This migration is anticipated to continue, with more migrants needing health care, education, and social services. Little is known about their perceptions of barriers to health care services or the factors that influence their health-seeking behaviors.

Focus groups and key informant interviews provided rich data, which were analyzed using content analysis. Themes revealed included: (a) barriers to seeking and maintaining health; (b) social and cultural factors influence health-seeking behaviors; and (c) political influences affecting migrants. Major barriers identified were financial issues, difficulty in obtaining care due to long wait times, transportation problems, and struggles with language and cultural nuances of communication. The women relayed a mistrust of health and social services resulting from communication barriers. The literature supported the findings related to barriers and mistrust exacerbated by linguistic and cultural barriers. Social and cultural factors included the use of traditional Chuukese medicines, lack of preventive care services, Chuukese gender norms, the role of women, and confidentiality concerns. The finding of confidentiality concerns was unique to this research study. Key informants reported immense educational barriers that influenced the health-seeking and health maintaining behaviors of the Chuukese migrants. Qualitative research studies on Micronesian migrants in the United States supported the themes of educational needs and lack of preventive care. Participants gave recommendations to improve care for Chuukese migrant women in Guam. There was a call to action from participants and a strong desire to achieve the mutual goal of improved care for Chuukese migrants in Guam.
Chuukese Migrant Women in Guam: Perceptions of Barriers to Health Care

Chapter 1

Since the implementation of the Compact of Free Association with the United States in 1985, large numbers of migrants from the nearby Micronesian islands have come to Guam (U.S. Department of the Interior, 2003). Evidence demonstrates these migrants experience disparity in several areas of health and socioeconomic status, such as higher rates of poverty, lower income and educational levels, and lower rates of prenatal care. Disparities in health and socioeconomic status affect Micronesian women in Guam. Data in Guam revealed lower rates of prenatal care for Micronesian women (Guam Bureau of Statistics and Plans, 2005), higher rates of diabetes during pregnancy, and increased risk of delivering large for gestational age infants (Alur, Kodiyanplakkal, Del Rosario, Khubchandani, Alur, & Moore, 2002). Chuukese women maintain the role of primary caregiver for children and peacekeeper within the family. Migration may cause a disruption in the traditional family structure, leaving women with increased stressors but fewer supportive structures (Moral, 1998; Shoultz, Magnussen, Hansen, Selifes, & Ifenuk, 2007).

Additionally, the Chuukese culture has a strong incest taboo with strict and complex gender norms (Moral, 1998; Hezel, 2001). These norms establish a pattern of avoidance behavior between men and women. These gender norms are an important consideration for a female researcher working with the Chuukese. These cultural aspects will be discussed in more detail and are relevant to the methods in which this study was conducted. Little is known about the perceptions of barriers to health care services or the factors influencing the health-seeking behaviors of this population. This study centered on the perceptions of barriers to health care faced by Chuukese migrant women in Guam.

After the end of World War II, in 1947, the United Nations (UN) established the Trust Territory of the Pacific Islands (TTPI) and granted authority over these islands to the United
States (Greico, 2003). The Trust Territory of the Pacific included the islands of the Federated States of Micronesia (FSM), the Marshall Islands, Palau, and the Northern Mariana Islands (Joint Committee on Compact Economic Negotiations, 2002) (see Appendix A for area map). The UN also mandated that the United States support efforts towards self-determination of the political status of each of the nations governed under the Trusteeship (Joint Committee on Compact Economic Negotiations, 2002).

The Trusteeship continued until 1986, when the UN affirmed that the governments of these island nations had exercised their right to self-determination. The UN further resolved that the United States met the obligations under the Trusteeship Agreement. The Trusteeship was terminated resulting in self-governance of these nations (Joint Committee on Compact Economic Negotiations, 2002). Subsequent to the dissolution of the Trusteeship, the United States and the governments of the Federated States of Micronesia and the Marshall Islands entered into agreements known as the Compact of Free Association. The Compact began a new phase in the relationship between the United States and these island nations (U.S. General Accounting Office, 2002).

The Compact is a joint act of the U.S. Congress and the Executive branches that delineated relationships between the United States and the island governments. The Compact provided benefits from the United States including the funding of economic development, the use of U.S. currency and mail services, and immigration privileges. In exchange for such benefits, each of the Pacific nations in the Compact guaranteed the United States exclusive use of its land, sea, and airspace for military purposes (U.S. Department of the Interior, 2003).

The Compact granted special immigration status to the residents of these Micronesian islands. They are not required to meet U.S. visa and labor certifications in order to live and work in the United States (U.S. General Accounting Office, 2002). The immigration benefits afforded
by the Compact have influenced the migration patterns of these Micronesians. These Micronesians are often referred to as Compact migrants (U.S. Department of the Interior, 2003). Prior to the Compact of Free Association, residents from the Federated States of Micronesia migrated to other islands in small numbers (Greico, 2003). Since the implementation of the Compact in 1986, large numbers of migrants from the nearby Micronesian islands have come to Guam (U.S. Department of the Interior, 2003). The total population in Guam for 2004 was 166,090 with 11,779 from the Compact nations. The majority (approximately 56.5%) of the Compact migrants in Guam were from the FSM state of Chuuk (Government of Guam, 2005). The Chuukese constitute the largest of the migrant groups in Guam (Government of Guam, 2005). The focus of this research was the Chuukese migrants from the Federated States of Micronesia (Government of Guam, 2005).

**Background**

**Health Disparities in the United States**

As a nation, the United States has made significant improvements in the methods of preventing, diagnosing, and treating diseases. These developments have resulted in the dramatic improvement in the health of many Americans and have led to a system considered to be among the most advanced in the world (U.S. Department of Health and Human Services [U.S. DHHS], 2004). Significant reductions have been made in several indicators of health such as infant mortality rates, and mortality rates from stroke and coronary heart disease (U.S. DHHS, 2000). The infant mortality rate in 2003 was 6.9 deaths per 1,000 live births. This rate was 76% lower than the infant mortality rate of 29.2 deaths per 1,000 live births in 1950 (National Center for Health Statistics [NCHS], 2006). Mortality rates from diseases of the heart declined 63% from 1950 to 2004, while the mortality rate from cerebrovascular diseases declined from 180.7 deaths
per 100,000 in 1950 to 50.0 per 100,000 in 2004. This accounted for a 72% reduction in deaths due to cerebrovascular diseases (NCHS, 2006).

This progress has contributed to an overall improvement in the health status of Americans over the past 100 years (U.S. DHHS, 2003). Not all members of society, however, are benefiting equally from these advances (Aday, 2001; Institute of Medicine [IOM], 2003; Mullins, Blatt, Gbarayor, Yang, & Baquet, 2005; U.S. DHHS, 2006, 2011a). Evidence demonstrates that inequities exist in life span, healthcare use, and health status among different ethnic, racial, and socioeconomic groups in the United States (Hebb, Fitzgerald, & Fan, 2003; National Research Council, 2004; IOM, 2003; U.S. DHHS, 2003, 2006, 2011b). Infant mortality for non-Hispanic black infants was higher than that of any other racial group from 2001 to 2003, with a death rate of 13.6 per 1,000 live births compared to the U.S. national rate of 6.9 deaths per 1,000 live births (NCHS, 2006). Cancer related disparities exist for minorities as well. Black women have a lower incidence of breast cancer than White women do; however, their mortality rate is higher. Black women are more likely than White women to have advanced stage breast cancer when it is first detected (Gornick, Eggers, & Riley, 2001; Ross, 2000, U. S. DHHS, 2011a). Hebb et al. (2003) conducted a national review of Medicare beneficiaries and found evidence of disparities in the use of outpatient procedures such as mammograms for Blacks, Hispanics, and American Indians/Alaskan Natives. The overall rate of mammogram screening for Medicare beneficiaries was 55.8%, but the rate for Blacks was 9% lower than the overall rate. The rate for Hispanics was almost 10% lower, while the rate for American Indians/Alaskan Natives was 20.3% lower than the overall rate (Hebb et al., 2003).

Disparities exist in both health and health care. Health refers to an individual’s condition, while health care refers to the process of treating illness or injury (National Research Council,
The World Health Organization (WHO) (1986) defined health from a broad perspective; health is:

The extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical capacities. (p. 73)

The WHO definition includes the concept of social health. Social health is important to the vitality of a community. Social health is adversely affected by negative interactions leading to problems of poverty, violence, and lack of opportunity for groups within a community (Nies & McEwen, 2011). This social view of health provides a broad framework from which to study the issue of health disparities. The U.S. DHHS, in *Healthy People 2010*, identified elimination of disparities as one of two overarching goals. This goal identified health disparities occurring by gender, race, ethnicity, income, disability, sexual orientation, and geography (U.S. DHHS, 2000).

**Definitions of Health Disparity**

The U.S. Congress has defined health disparity as differences in overall rates of disease incidence, morbidity, mortality, or survival in specific groups of people as compared with the general population (National Center on Minority Health and Health Disparities, 2001). The Institute of Medicine (IOM), in its groundbreaking work *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003), defined health care disparities as “racial or ethnic differences in the quality of care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention” (p. 4). The IOM established a committee to study the issue of disparities. The Committee on Understanding and Eliminating Racial and
Ethnic Disparities in Health Care held the assumption that even when accounting for access-related factors, such as income and insurance status, differences exist in the quality of health care provided to minorities (IOM, 2003). The IOM committee was tasked with assessing whether discrimination, bias, or stereotyping at all levels of health care (individual, institutional, health care system) may contribute to these disparities in the quality of care given to minorities in the U.S. (IOM, 2003).

The Agency for Healthcare Research and Quality (AHRQ) designated specific groups affected by disparities as “disparity populations.” These are defined as “those groups for which there is a significant disparity either in the quality, outcomes, cost, or use of health care services or in access to or satisfaction with such services as compared to the general population” (Fiscella, 2003, p. 15). The AHRQ provides annual reports of disparities and quality care with a specific focus on these identified populations (U.S. DHHS, 2003).

**Healthy People 2010 and Healthy People 2020**

*Healthy People 2010* (U.S. DHHS, 2000) was a national initiative for health promotion and disease prevention nationwide. The two overarching goals of the initiative were to increase quality and years of healthy life and to eliminate health disparities. It was based on the premise that the health of the individual is closely tied to the health of the community in which the person lives. The vision of this national agenda was to achieve healthy individuals in healthy communities (U.S. DHHS, 2000).

While strides have been made in the improvement of the health of the nation, disparities remain and the goal of eliminating disparities remains unfulfilled (Fiscella, 2003; Mullins, Blatt, Gbarayor, Yang, & Baquet, 2005; U.S. DHHS, 2000, 2006, 2011a). *Healthy People 2010* documented significant examples of health and health care disparities (U.S. DHHS, 2000). Infant mortality among Blacks, American Indians, and Alaskan Natives was more than double that of
Whites. Death from HIV/AIDS was more than seven times higher for Blacks than for Whites. Heart disease, cancer, and diabetes affect those living in rural areas at higher rates than those in urban areas, and the suicide rate for male homosexual adolescents was two to three times higher than for heterosexual adolescent males (U.S. DHHS, 2000).

The *Healthy People 2010 Final Review* presented an assessment of the progress made over the course of the past decade. Significant health disparities remain with no change in health disparities among racial and ethnic populations for 69% of measurable objectives tracked by *Healthy People 2010* (U.S. DHHS, 2011a). The rate of death from HIV infection for Black non-Hispanics was almost 12 times greater than the rate for white non-Hispanics in 2007. The disparity between White and Black non-Hispanics death rate from homicide grew 234% from 1999 to 2007. The death rate for Blacks was 21.8 per 100,000 in 2007 while the death rate for Whites during the same year was 2.9 deaths per 100,000. The infant mortality rate for the nation declined overall from 1998 to 2006 from 7.2 to 6.7 per 1,000 live births. However, for Black non-Hispanics, infant mortality in 2006 was 13.4 per 1,000. These statistics are a few examples of the continued problem of health disparities faced by the United States (U.S. DHHS, 2011a).

With the end of the decade, Healthy People 2010 ended and the transition to Healthy People 2020 was launched. *Healthy People 2020* is the current health promotion initiative building on the foundation set by *Healthy People 2010*. *Healthy People 2020* has four overarching goals to:

1. Attain higher quality, longer lives free of preventable disease, disability, injury, and premature death.
2. Achieve health equity and eliminate disparities.
3. Create social and physical environments that promote good health for all.

The vision of Healthy People 2020 is to produce a society in which all members live long, healthy lives. While building on previous decades of Healthy People initiatives, Healthy People 2020 has an added emphasis on health equity. There is an explicit recognition of the complex inter-relationships between social, environmental, policy, organizational, biological, and psychological factors influencing health status and health behaviors. This new emphasis on equity promotes development of strategies to address social determinants of health and promote those efforts that foster health for all members of society and across all stages of life (U.S. DHSS, 2011a).

Asian American/Pacific Islander Populations

The umbrella term Asian American Pacific Islander (AAPI) includes many unique ethnic and cultural groups. The value of this term is political in nature; the federal government uses it as a means to organize these diverse groups of peoples for funding and census purposes (Yamashiro & Matsuoka, 1997). In the United States, the AAPI population is the fastest growing minority group, comprising 4% of the total U.S. population. By the year 2050, estimates predict this group will grow to 11% of the population, or 41 million people. This category includes those with roots in at least 29 Asian nations and 20 Pacific Islander countries (Ghosh, 2003).

The U.S. Census Bureau includes over 40 different groups in the AAPI category and defines Asians as those who have origins in the Far East, Southeast Asia or the Indian subcontinent. The Census 2000 provided for detailed groupings of Asians into 24 subcategories including those from Japan, Korea, China, Vietnam, Thailand, Cambodia, Sri Lanka, Taiwan, Malaysia, the Philippine Islands, Pakistan, and India (U.S. Department of Commerce, 2002).
The U.S. Census Bureau defines Pacific Islanders as those with origins in any of the original peoples of Hawaii, Samoa, Guam, or other Pacific Islands. The Census 2000 further divided the Pacific Island populations into over 23 different groups, such as those with origins in Micronesia (for example, Saipan, Palau, Chuuk, Yap), those from Melanesian origins, such as those from Fiji, Papua New Guinea, and the Solomon Islands, and those with Polynesian roots, such as those from Samoa, Tonga, Tahiti, and Hawaii) (U.S. Department of Commerce, 2001a).

Many misconceptions and myths hamper our understanding of this population (Fong & Mokuau, 1994; Louie, 2001). Lack of responsiveness to the health care needs of Asian American Pacific Islanders (AAPIs) may be due in large part to the lack of descriptive and analytical information and knowledge about the unique groups within this growing population (Fong & Mokuau, 1994; Srinivasan & Guillermo, 2000). The diversity, relatively small subgroup sizes, and wide geographic distribution of AAPIs in the United States have contributed to the lack of data and understanding (Ro, 2002). The aggregation of AAPI data in the United States has resulted in lack of data and knowledge of the unique AAPI subgroups (Ghosh, 2003; Ro, 2002; Srinivasan & Guillermo, 2000).

**Compact of Free Association**

The United States entered into agreements called the Compact of Free Association Act of 1985, which established a relationship with the Federated States of Micronesia and the Republic of the Marshall Islands. In 1994, the Republic of Palau (ROP) negotiated with the United States and was included in the Compact. These three countries are collectively referred to as the Freely Associated States (FAS) (Guam Bureau of Statistics and Plans, 2005). The Compact gave the United States exclusive use of land, airspace, and territorial waters for military purposes. In exchange, the islands received economic aid and its residents were given the right to migrate freely, reside, and to seek employment in the United States, its territories and commonwealths.
This included Guam and the Commonwealth of the Northern Mariana Islands (CNMI), which are geographically close to the FSM (Greico, 2003). Citizens of the FAS are able to establish residence as non-immigrant aliens (Government of Guam, 2005).

Before the Compact was implemented, small numbers of Micronesians emigrated. After the Compact took effect, however, the numbers emigrating rose dramatically (Greico, 2003). One hundred and ninety Micronesians were reported to have migrated to Guam in the period from 1985 to 1986 from the Compact nations. This number rose to 898 in the two-year period from 1987 to 1989 and continued to rise, as evidenced by the 1997-1998 Census data showing 5,446 post-Compact Micronesian migrants living in Guam (U.S. Department of the Interior, 2003). By 2003, the number of FAS migrants in Guam rose to 9,366 (Government of Guam, 2005). The 2010 data shows a continued and dramatic rise in the migrant population, with 22,086 FAS citizens migrating that year under the Compacts of Free Association (Government of Guam, 2011).

**Federated States of Micronesia**

The FSM is located in the northern part of the Pacific Ocean between Hawaii and Indonesia. Part of the island grouping called Micronesia, FSM has a population of 108,105 and consists of 607 islands which are divided into four states: Chuuk (formerly Truk), Pohnpei (formerly Ponape), Kosrae, and Yap (Witherbee, 2005). Although the islands are scattered over one million square miles, the total land area is only 271 square miles. The islands range from large, mountainous islands to tiny atolls (Greico, 2003). Atolls are islands that have sunk beneath the surface of the ocean, leaving a ring of coral reef and small islands remaining above the water (FSM Visitors Board, n.d.). The majority of FSM residents are ethnically Micronesian with a few Polynesian ethnic groups.
Republic of the Marshall Islands

The Republic of the Marshall Islands is located about 2,200 miles west of Honolulu, and 1,600 miles east of Guam. It has a land mass area slightly larger than that of Washington, D. C. and a population of 57,738. The RMI consists of two chains, including the atolls of Kwajalein, Bikini, Eniwetok, and Majuro (Pacific Resources for Education and Learning, 2005). Most of the RMI migration has been to Hawaii and the U.S. mainland rather than to Guam (U.S. Department of the Interior, 2003).

Republic of Palau

The Republic of Palau is less than 500 miles east of the Philippines and is the westernmost U.S. jurisdiction in Micronesia. It has a land area of 188 square miles and consists of several hundred volcanic islands. The population of 19,100 people inhabits nine of these islands (Pacific Resources for Education and Learning, 2005a). Palauan migrants have been moving to Guam since the 1950s, during the early TTPI government. Of the FAS migrants, Palauans have had the longest years of residence in Guam and Hawaii (U. S. Department of the Interior, 2003).

Chuuk State

Chuuk is the most populous of the Federated States of Micronesia with 59,367 people living on a land area of 49 square miles (Pacific Resources for Education and Learning, 2005b). Chuuk means mountains or hills, and refers to the fact that Chuuk is composed of 17 high, mountainous islands along with low, sandy, atolls. Chuuk has an expansive reef, enclosing a deep-water lagoon (Goodenough, 2002). In addition to the volcanic islands in the lagoon, there are 24 atolls lying outside the lagoon area. In total, Chuuk is made up of close to 290 islands (Pacific Resources for Education and Learning, 2005b). Chuuk is approximately 634 miles from
Guam and 3,492 miles from Honolulu, Hawaii (FSM Visitors Board, n.d.). (See Appendix B for map).

**Chuukese Culture**

**The lineage.**

The fundamental unit of Chuukese society is the lineage, which is traced along the female lines. The lineage consists of the oldest female and all the women and their children in the line. The entire matrilineal group would ideally live together on a single property and function as a distinct corporation or economic unit of its own. The lineage is vitally important in the life of the Chuukese; one’s identity is derived from the lineage (Moral, 1998). The definition of family in traditional Chuukese society referred to the matrilineal group rather than the individual nuclear family (Hezel, 1992). The western concept of individuality does not exist for the Chuukese. The lineage defines an individual. The lineage is viewed as the protector and provider of all members (Moral, 1998). In traditional Chuukese society, the role of the woman includes a responsibility to maintain a unity between the land and the lineage group. Women guarantee survival of the lineage through childbirth, and are responsible for transfer of land within the matrilineal group (Moral, 1998).

The matrilineal estate includes several residential houses in which nuclear families sleep together, but may also include unmarried relatives or more than one nuclear family. The food preparation and eating do not occur in the residential house. A cookhouse, or *fanang*, is separate from the residential house. The estate usually has one cookhouse shared by all. A central meeting house, or *uut*, is used for gatherings, as the sleeping quarters for unmarried young men, and as a male hangout. The young men are not allowed to sleep with their adolescent sisters in the same house (Hezel, 1992).
Avoidance behaviors and incest taboo.

In Chuukese culture, there is a significant incest taboo tied to the relationship between sister and brother that greatly affects the status of women. All close male members of a woman’s clan are considered her brothers. The incest taboo sets up complex standards of avoidance behavior. Brothers must be kept physically away from sisters, and sisters must remove any type of sexual connotation from their behavior, body, and presence. Rules of modesty for women are strong. Moral (1998), in explaining the seriousness of the incest taboo, stated, “The ideal behaviour for a sister is to pretend that she is not there (that is the only way for all sexual connotations to disappear)” (p. 276).

When young men reach puberty, they move to the male sleeping house or to another residence house with no ‘sisters’. Brothers and sisters must not discuss any matters regarding sexuality. The incest taboo extends to the act of elimination of bodily wastes. Chuukese avoid the act of elimination of bodily wastes in the presence of persons considered brothers or sisters. Brothers and sisters, referred to as cross-siblings, are not to be alone together, and finding them alone together is a grievous offense. Sisters must avoid their brothers and cannot speak harshly to a brother unless his behavior violates the normative cross-sibling behaviors (Marshall, 1979).

Hezel (2001) described the gender relations among Chuukese men and women as being reciprocal. The rules governing the behavior of women towards men, in particular, to male relatives, are strongly followed. Males, however, are also expected to display respectful behavior towards women (Hezel, 2001). In keeping with the strong avoidance behaviors considered normative in Chuukese society, male relatives are expected to withdraw themselves from the presence of close female relatives (Hezel, 2001). This avoidance behavior affects social behaviors of both genders. Brother-sister avoidance sets up a pattern in which brothers avoid
settings in which their sisters frequent. This results in boys and young men spending little time in and around the house in efforts to maintain this avoidance behavior (Lowe, 2003).

In Chuukese society, there is an inherent view of male superiority. Although the society is matrilineal, there is a belief that men’s roles include the protection of the women. Men are considered more capable and stronger than women. Women are perceived as weaker, and dependent on men for protection. In terms of the role as guardian of the unity of the clan or lineage, however, women maintain responsibility above the prestige of the men. Women’s responsibility to maintain and foster the perpetuation and unity of the clan or lineage “gives women the last word, but has to be performed in silence. In the old days, the simple presence of a woman in a battlefield was enough for the conflict to end, without a single word said” (Moral, 1998, p. 277).

The role of women.

The limitations set up by the incest taboo significantly affect the ability of women to speak in public forums, because there will always be brothers present in the gathering. The incest taboo and the view of male superiority create a culture of silence for women. Women do not participate openly in public gatherings. Women have resorted to other strategies in order to take part in decision-making. The importance of the role in maintaining the lineage allows women in Chuuk legitimacy derived from this lineage structure (Moral, 1998).

Men and women in Chuuk have their own spheres of influence in terms of power and roles. While men maintain the role as public spokesperson for the lineage, women are the guardians of the land and the lineage (Hezel, 2001; Moral, 1998). The senior woman in the lineage has the authority to make decisions regarding land usage. Any member who wants to give away a piece of lineage land must seek approval from the senior woman (Hezel, 2001). In
addition to guardianship of the lineage land, other roles of women include peacemaker and advisor on family and community matters (Hezel, 2001; Moral, 1998).

As peacemakers, women are to protect their male relatives from harm, including physically removing them from harm in cases of fights or arguments with others. Women provide advice and counsel in family and community matters. While the source of women’s power and authority is often indirect and hidden from public view, it is important to recognize the valuable role women play and the significant contributions made to the extended family and to the community (Hezel, 2001). Although the power given to women is practiced in silence, the importance of this role of women is transmitted within the intimate boundaries of the family. This importance of the women as guardian of the unity of the family is passed on from generation to generation (Moral, 1998).

In terms of childrearing practices in Chuukese society, the mother is primarily responsible for the rearing of young children and the older girls, while the father is responsible for the older boys in the family unit. Other adult members of the lineage take part in raising the children; however, this practice is diminishing. In households where the parents have moved away from the lineage to another site of residence, the parents are often the sole caretakers of their children (Hezel, 1992).

Changes are occurring in land inheritance and land transfer practices in Chuuk. These changes affect the role of women as guardians of the land. Increasingly, individuals, rather than kinship groups own land (Hezel, 2001). An important source of power that women hold in Chuuk is directly linked to the matrilineal nature of land tenure (Hezel, 2001; Moral, 1998). With the erosion of the lineage, however, this strength is also diminishing (Moral, 1998). Another source of change is in the lineage. In particular, as migration to Guam occurs, the loss of the lineage bonds occurs. The nuclear family is becoming more commonplace with lessening of the
ties to the lineage, resulting in erosion of the role of women as protector of the lineage (Hezel, 2001).

A significant societal change occurring in Chuuk is the diminishing importance of the lineage and the increasing importance of the nuclear family. The extended family structure of the lineage afforded women strength and protection (Hezel, 2001; Moral, 1998). A woman’s family provided security and protection, even in cases of abuses from her husband. The extended family had the duty and right to protect all members of the lineage group. The dissolution of the lineage leaves women without the protection previously provided by the group. As the role of the male as head of a nuclear household grows, intervention from extended family members is considered intrusive and unacceptable (Moral, 1998). According to Moral (1998), this loss of protection for women through the lineage has resulted in an acceptance of domestic violence. The extended family, and in particular, the male relatives of females, protected women from harm. As families move out of Chuuk, the nuclear family is not able to provide the same level of protection to women (Shoultz, Magnussen, Hansen, Selifes, & Ifenuk, 2007). This weakening support for women is evident as well in the event of giving birth. This important life cycle event was a time for women to receive support from the women in their lineage group. Women are less likely to return to their land to give birth, and less likely to have the support of their mothers and sisters during this momentous event (Hezel, 2001). The implications of these cultural changes are relevant to the study of migrant Chuukese women (Shoultz et al., 2007).

**Significance**

Micronesian migrants in Guam experience disparities in several areas of health and socioeconomic status (Alur, Kodiyanplakkal, Del Rosario, Khubchandani, Alur, & Moore, 2002; Guam Bureau of Statistics and Plans, 2005, 2011; Salvation Army, 2005). In 2004, 46.8% of women in Guam who did not receive any prenatal care were from the FSM, representing the
highest racial group lacking prenatal care (Guam Bureau of Statistics and Plans, 2005). Higher rates of poverty were documented among the Compact migrants. In 2003, 45.2% of Compact migrants in Guam lived below the poverty level with 80.8% of those reportedly below the 185% poverty level (Guam Bureau of Statistics and Plans, 2005, 2011).

The numbers of homeless people reporting Chuukese ethnicity has been increasing, as reported in the most recent surveys of homeless in Guam (Salvation Army, 2005; Salvation Army & Guam Housing and Urban Renewal Authority, 2007). Those homeless who reported Chuukese ethnicity for the head of household made up 15.71% of the homeless population (Salvation Army, 2005); in 2007, the number rose to 16.26%. The Chuukese ranked second in numbers of homeless by ethnicity overall in both reports (Salvation Army and Guam Housing and Urban Renewal Authority, 2007).

The Census 2000 report, *Children in Guam* (2002), indicated there were higher levels of children living in poverty in villages with higher levels of recent migration. The child poverty rate in Guam rose during the 10-year period from 1989 to 1999, while the overall U.S. national child poverty rate dropped. The rate of children living in poverty in Guam increased from 19% in 1989 to 29% in 1999, while the overall U.S. national rate of children living in poverty dropped from 18% to 16% during that same period (Annie E. Casey Foundation and the Population Reference Bureau, 2002).

**Economic Impact of the Compact of Free Association**

When Congress enacted the Compact of Free Association, it included provisions for compensating U.S. territories, commonwealths, and the state of Hawaii for any adverse consequences resulting from implementation of the Compact. It agreed to appropriate sums of money necessary to cover the costs of increased demands on educational, health, safety, and
social services by the immigrants from the FAS. These costs are referred to as Compact Impact costs (U.S. Department of the Interior, 2003).

In the 2000 Impact Report, Guam’s most significant burden in health services was to a publicly funded hospital, the only civilian hospital on the island. Unpaid health care services to FAS patients totaled over $5.4 million. Hospital officials voiced concerns because the majority of FAS patients use the emergency room for primary care services and not for emergent care needs. In 2000, this specific Emergency Department (ED) treated about 3,000 patients a month. Although the FAS population represented only 5% of the total Guam population, it comprised 12% of patients treated in the ED in 2000 (U. S. General Accounting Office, 2001). No current data were published for this hospital’s costs since 2004.

The un-reimbursed Compact Impact costs for Fiscal Period (FP) 1987-2003 totaled $269 million. This includes $48 million for health, welfare, and labor, and $178 million for education. The remaining $43 million went towards ensuring public safety. The $43 million includes costs for the Guam Police Department, Department of Youth Affairs, Guam Fire Department, Superior Court, Public Defender Services, Department of Law, and the Department of Corrections. The un-reimbursed costs for education and safety in Fiscal Year (FY) 2004 were over $21.5 million. The Island’s publically funded hospital reported $13,114,262 in un-reimbursed costs. This represents 6,775 total patient encounters, visits, or admissions by patients who identified themselves as coming from the FAS. The Guam Department of Public Health and Social Services did not provide data for its clients from the FAS for the report. The costs for FY2004 are unaudited amounts as reported in the FY 2004 Compact Impact Report (Government of Guam, 2005).

The FY 2010 Compact Impact Report (Government of Guam, 2011) detailed increases in expenses for FAS citizens. The costs for providing education and social services to the citizens
of the FAS for the years 2004 to 2010 were a total of $324.5 million. The Department of Education in Guam reported a dramatic increase in costs for FAS citizens seeking a public education. The costs for FY 2004 were $15,501,638 and a total of $28,124,073 in FY 2010. The total unreimbursed costs for the Government of Guam rose from $58.69 million in FY 2009 to $63.69 million in FY 2010. This is a dramatic increase from the $28.17 million reported in FY 2005 (Government of Guam, 2011).

In Hawaii, more than 8,000 Micronesians have migrated under the auspices of the Compact of Free Association. The majority of the islanders come from the Marshall Islands, which is geographically the closest to Hawaii. Chuukese migrants are the fastest growing Micronesian migrant community in Hawaii (Pobutsky, Buenconsejo-Lum, Chow, Palafox, & Maskarinec, 2005). The estimated cost to the government of Hawaii from 1996 to 2000 was $86 million for health care, education, and welfare services provided to the Micronesian migrants. The vast majority of the $86 million went to health care costs (U.S. General Accounting Office, 2001). In a 2001 report to Congress, the U.S. General Accounting Office reported that the Hawaii government had not been reimbursed for those costs. Government officials from Guam, Hawaii, and the Commonwealth of the Northern Mariana Islands (CNMI) have conveyed dissatisfaction with the current economic situation (U.S. General Accounting Office, 2001). These governments have communicated their frustrations and concerns that the islands are bearing the burden of federal legislation, which allows unrestricted migration through the Compact of Free Association (U.S. General Accounting Office, 2001). Hawaii, Guam, and the CNMI reported more than $1 billion in costs for services provided to compact migrants for fiscal years 2004 through 2010. These costs were for education, health, and social services provided to the migrants; the U.S. government awarded approximately $210 million in funds to offset the
compact costs; however, this falls short of the actual cost (U. S. Government Accountability Office, 2011).

**Complexity of Disparities in the United States**

The IOM (2005) cited many barriers that contribute to disparities. Among them were systemic problems involving health systems, health plans, patients’ attitudes, and health-seeking behaviors that affect health care. Provider biases, prejudice, and uncertainties when treating minority patients can also lead to care that is not equitable. The complexities of the health system, time constraints, and financial issues also may affect the care received by minority patients (IOM, 2005). Although many federal agencies are engaged in the ongoing efforts to decrease health disparities, these continue to persist, particularly for minority groups in the United States. (Mullins et al., 2005).

The issue of disparities is a complex one. Many factors may lead to differences in health outcomes and health care. Individual factors that may play a role in disparities include gender, ethnicity, genetic predisposition, lifestyle choices, income, educational level, insurance status, health-seeking behaviors, health literacy, and perceptions of health and illness (Harrison & Falco, 2005; Johnson & Smith, 2002). Family, community, environmental, and socioeconomic factors such as poverty, culture, language, family structure, residential stability, race and ethnicity, discrimination, and racism also influence disparities. The current understanding of these factors and the relationship of these factors to health care access, quality and health outcomes is inadequate (Johnson & Smith, 2002).

The IOM, in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003) discussed significant implications of the existence of disparities on the U.S. health care system. The IOM asserted that racial and ethnic disparities would be one of the most significant challenges facing the rapidly evolving health system. Issues such as social justice,
equal opportunity, quality of life for all, and distribution of limited resources would confront health care professionals and policy makers (IOM, 2003). From a public health perspective, disparities hamper the mission to improve the health of the entire nation (Fiscella, 2003; IOM, 2003). The higher burden of disease among minorities will ultimately result in higher costs for health care that will affect all Americans. All members of a community are affected by the health status of its least healthy members. Inadequate care will have an economic impact on the future costs of healthcare in the nation (IOM, 2003).

The first National Healthcare Disparities Report (U.S. DHHS, 2003) highlighted the economic significance of health disparities. Although health care disparities may be experienced at an individual level by various subgroups within our nation, the impact is felt at a societal level. Expensive complications, long-term health problems, and avoidable complications may be caused by poorly managed care, late or missed diagnoses, and lack of preventive services (IOM, 2003; U.S. DHHS, 2003). Personal costs of health care disparities can lead to lost productivity, decreased quality of life, morbidity, and disability. Poor outcomes due to health care disparities may contribute to higher health insurance costs, increased costs borne by taxpayers, and higher malpractice costs. For example, poorly managed diabetes may result in end-stage renal disease, which is a very costly condition. These increased costs may further stress our health care system and threaten its viability (U.S. DHHS, 2003).

The 2006 National Healthcare Disparities Report (U.S. DHHS, 2006) revealed that disparities continue to be pervasive in almost all aspects of health care, including access to care, quality of care, and across many types of care ranging from preventive care to management of long-term diseases. For example, Blacks had 90% more lower extremity amputations for diabetes than did Whites in the same reference group. In terms of access to care, Blacks and Asians/Pacific Islanders had worse access to care than Whites did for one-third of the core
measures in the NHDR. Poor people had less access to care than high income people for all access-specific core measures. Trend data revealed that some disparities were decreasing over time, but others had increased. Increasing disparities were particularly evident for minority groups in chronic disease management. For Blacks, Asian/Pacific Islanders, and Hispanics, approximately 25% of quality measures were improving; however, about one-third of disparities in quality demonstrated an increase over time (U.S. DHHS, 2006).

The 2007 *National Healthcare Disparities Report* (U.S. DHHS, 2008) reviewed the progress the nation has made since the first *NHDR* was published in 2003. Overall, disparities in quality of care for minorities and poor populations had not decreased since the first *NHDR*. Progress has been made in some areas. For example, the disparity between Black and White hemodialysis patients receiving adequate dialysis was completely eliminated in 2005; in 2004, the disparity between Asians and Whites who report having a usual primary care provider was eliminated as well (U.S. DHHS, 2008). The largest gaps identified in previous reports, however, are not improving. For Blacks, Asians, Hispanics, and other poor populations, at least half of the measures used to track access to care are not improving and over 60% of disparities in quality are not decreasing (U.S. DHHS, 2008). For example, the proportion of new AIDS cases in 2007 was 10 times higher for Blacks than for Whites and more than three times higher for Hispanics than for non-Hispanic Whites (U.S. DHHS, 2008).

The 2008 *National Healthcare Disparities Report* (U.S. DHHS, 2009) documented that while disparities for certain priority populations in specific areas were eliminated, many of the largest gaps had not significantly improved. There was a demonstrated improvement for American Indians and Alaskan Natives in 75% of core measures of access to care, the percentage of Hispanic children receiving a vision check improved from 51.6% in 2000 to 56.6% in 2005,
and the percentage of adult smokers who received counseling for smoking cessation while hospitalized increased from 57.9% in 2000 to 65.5% in 2005 (U.S. DHHS, 2009).

The largest gaps reported in the 2007 NHDR continued to persist in 2008. For Blacks, the largest disparities continued to remain in the number of new AIDS cases. The proportion of new AIDS cases was 9.4 times as high for Blacks as for Whites. The lack of prenatal care for pregnant Black women in the first trimester was among the highest areas of disparity documented in the 2008 NHDR (U.S. DHHS, 2009). The proportion of new AIDS cases for Hispanics was more than 3 times as high for Hispanics as for non-Hispanic Whites. Although the number of new AIDS cases among Hispanics and Blacks is decreasing, the proportion remains high when compared to non-Hispanic Whites. The disparity in receiving screening for cancer through colonoscopy, sigmoidoscopy, proctoscopy, or fecal occult blood testing increased for Blacks, American Indians and Alaskan Natives, Asians, and Hispanics age 50 and over. This disparity increased between 1999 and 2006 for all four minority groups (U.S. DHHS, 2009).

The most recent data were reported in the National Healthcare Disparities Report 2011 (U. S. DHHS, 2012). Quality measures demonstrated slow improvement, but this improvement did include all ethnic, age, race, and income groups. Unfortunately, in the area of access to health care, approximately half of the measures did not show improvement, with 40% of measures worsening. The report called for “urgent attention” in order to reduce disparities, particularly in the areas of diabetes care and adverse outcomes, cancer screening and access to health care. The rate of advanced stage breast cancer in Black women worsened, with an increase from 99 to 108 per 100,000 women. For this measure, there were no significant changes for other ethnic groups. There was improvement in the proportion of new AIDS cases among Blacks when compared with Whites; however, the disparity still remained with the new AIDS cases in 2009 reported at
55.2 per 100,000 when compared to 5.5 per 100,000 for non-Hispanic Whites (U.S. DHHS, 2012).

The Agency for Healthcare Research and Quality (AHRQ) has produced the NHDR annually beginning in 2003. The AHRQ continues to provide data in efforts to encourage and support national, state, and local initiatives using national data and benchmarks in disparities. The provision of data through the NHDR is one of many national efforts undertaken in order to meet the goal of eliminating health care disparities in the nation (U.S. DHHS, 2009).

Another federal effort highlighting the ongoing problem of disparities faced by the nation is the first report from the Centers for Disease Control and Prevention (CDC) directly addressing disparities. The 2011 CDC Health Disparities and Inequalities Report (2011 CHDIR) was released as part of the government’s commitment to improve the health of the nation and reduce health disparities. This report is an effort to increase community awareness of disparities, providing information to assist in priority setting at the federal, state, and local levels, with the ultimate goal of reducing gaps in health and quality of life among the U.S. population (U.S. DHHS, 2011b). The 2011 CHDIR cited several key examples of disparity. Infant mortality rates continue to demonstrate significant disparities: Infant mortality is 1.5 to 3 times higher for infants born to Black women than for any other race/ethnicity. The prevalence of hypertension is much greater among Blacks than Whites, with a rate of 42% among Blacks and 28.8% among Whites. The CDC reported that the ongoing health disparities are not acceptable and can be corrected (U.S. DHHS, 2011b).

**Health Insurance Status**

Health insurance status is a major factor in accessibility of health care (IOM, 2003; U.S. DHHS, 2003). In 2005, the percentage of the U.S. population without health insurance coverage was 15.9%. This was an increase from the 2003 and 2004 rate of 15.6% (DeNavas-Walt, Proctor,
The rates of uninsured increased from a rate of 15.2% in 2002, to 15.6% in 2003 (DeNavas-Walt, Proctor, & Mills, 2004). The Census Bureau cited the economic recession that occurred from December 2007 to June 2009 as a factor that resulted in an increasing poverty rate in the nation. The poverty rate increased from 12.5% in 2007 to 15.1% in 2010. The rate of uninsured for the same period also rose. The rate of uninsured increased from 14.7% in 2007 to 16.3% in 2010 (DeNavas-Walt, Proctor, & Smith, 2011). The lack of insurance affects the ability to receive care for prevention of disease as well as for treatment of acute and chronic conditions. These patients may end up receiving more expensive care in hospital emergency rooms rather than seeking care from primary care providers. This may also cause increased severity of illness and more complications which also lead to increased health care costs (Young, 2004).

The number of foreign-born immigrants in the United States with health insurance is much lower than the number of native-born U.S. citizens with insurance. In 2002, 33% of foreign-born immigrants in the United States were uninsured; this is more than twice the number of uninsured U.S. natives (13% natives uninsured). Foreign born refers to anyone who is not a U.S. citizen at birth (Migration Policy Institute, 2004).

In 2005, 17.9% of Asians and 21.8% of Native Hawaiians and Other Pacific Islanders (NHOPIs) were uninsured. The rates of uninsured Asians and NHOPIs are significantly higher when compared to the rate (11.2%) of non-Hispanic Whites who were uninsured. This lack of insurance affects the Asian American Pacific Islander (AAPI) children as well with 12.2% uninsured in 2005, compared with 7.2% of non-Hispanic white children in the United States without insurance during the same period (DeNavas-Walt, Proctor, & Lee, 2006). The report on poverty and insurance coverage for 2006 did not include annual estimates for the Asian, Native Hawaiians or Other Pacific Islanders, and Alaskan Native or American Indian subgroups due to the relatively small sample sizes. The 3-year averages were reported. Native Hawaiians and
Other Pacific Islanders had a 3-year average (2004 to 2006) of 21.7% uninsured. Asians had a 3-year average of 16.1% (DeNavas-Walt, Proctor, & Smith, 2007). The most recent data included rates for Asians, but not for Native Hawaiians and Other Pacific Islanders. In 2009, the rate of uninsured Asians was 16.5% and in 2010, the rate increased to 18.1%. The rate of uninsured Whites as a comparison was 15.3% in 2009, and 15.4% in 2010 (DeNavas-Walt, Proctor, & Smith, 2011).

In a preliminary report on health insurance status in Guam, the proportion of the population that is uninsured is 22.6%. The uninsured are primarily the native Chamorros, the indigenous population of Guam with 36.2% uninsured. Of the total number surveyed, 41.7% were Chamorro. Peoples from the Freely Associated States made up 8.6% of the uninsured; yet represented 6.3% of the surveyed population (Guam Department of Public Health and Social Services [DPHSS], 2005).

While insurance status is an important factor in access to health care, the IOM cited a preponderance of studies demonstrating that racial and ethnic disparities remain even after adjusting for socioeconomic factors and access factors, such as insurance status (IOM, 2003). In a study of barriers to health care use by Blacks, Tarver (2000) reported that even when health care is available and affordable; other barriers to care exist and influence utilization. Among the barriers reported by study participants were fear, distrust, racism and delays before seeking care. This study demonstrated that other factors beyond insurance status played an important role in utilization of health care services by minority populations (Tarver, 2000).

The minority population in the United States continues to rise. According to the Census 2010 data, the Native Hawaiian and Other Pacific Islander (NHOPI) population was one of the fastest growing races in the United States between 2000 and 2010. The NHOPI population
increased 35%; at a rate more than three times faster than the total U.S. population. (U. S. Dept. of Commerce, 2012).

Research and Data Needs

An effort to define a baseline of information regarding Asian American/Pacific Islanders in the United States found serious deficiencies in the existing data. Healthy People 2010 was not an adequate reference because it relied only on national level data collection (Ghosh, 2003; Louie, 2001, Palafox & Kaanoi, 2000). The small sample sizes and geographic concentration of these ethnic minorities cause problems with data reliability. In addition, there is wide diversity within the AAPI population and aggregating them together is ineffective due to this diversity (Ghosh, 2003; Louie, 2001; Srinivasan & Guillermo, 2000). In order to more effectively deal with the issues of diversity, the health care community needs data and information on the individual subgroups. In addition to Federal research initiatives, local and state research efforts must be encouraged to increase understanding of these diverse subpopulations (Ghosh, 2003; Srinivasan & Guillermo, 2000).

The National Center for Health Statistics (NCHS) provides a yearly report on the health of the nation. In the 2004 report, the NCHS advocated for continuing data collection and sharing reliable information in order to identify how to combat the problem of disparities in the United States. This information about the determinants of health, resources, and outcomes will be vital to plotting the course for the future of health care delivery and policymaking (NCHS, 2004).

The 2006 National Healthcare Disparities Report (U.S. DHHS, 2006) and the 2007 National Healthcare Disparities Report (U.S. DHHS, 2008) highlighted the need for continuing data collection particularly for subpopulations of minorities. Disparities are pervasive and continue across all dimensions of health care including patient safety, patient centeredness, access to care, and health care utilization. The federal data sources have increased the ability to
measure information for more population groups; however, significant gaps continue to exist. Statistically reliable data estimates were not possible for most measures of quality and measures of access for Native Hawaiians and other Pacific Islanders (U.S. DHHS, 2006). These gaps must be addressed as they continue to impede the progress towards eliminating health disparities in the U.S. (U.S. DHHS, 2004).

The DHHS conducted a midpoint review of the Healthy People 2010 objectives to assess the status of the initiative in meeting the national objectives. This review is an opportunity to evaluate the trends in data for the first half of the decade, review new data, make recommendations for changes, and consider emerging public health priorities (U.S. DHHS, 2007). The *Midcourse Review* (2007) revealed that systematic reductions in disparity have not yet been achieved (U.S. DHHS, 2007). Among 195 objectives with data to evaluate trends, there were decreases in disparity among racial and ethnic populations for 24 objectives. There were increases in disparity, however, for ethnic and racial groups for 14 objectives and no change in disparity for 157 objectives (U.S. DHHS, 2007).

The *Midcourse Review* (2007) emphasized that elimination of disparities will occur only when greater reductions are seen for populations with the highest rates of disparities (U.S. DHHS, 2007). The lack of data for certain groups continues to limit a true assessment of disparity. Data for American Indians, Asians, Native Hawaiians, and other Pacific Islanders are limited. This limitation affected the ability to plan interventions to eliminate disparities and meet the goals of *Healthy People 2010* (U.S. DHHS, 2007). The *Healthy People 2010 Final Review* reiterated the need for improved data collection for minority populations. There were 354 objectives with measures for the white non-Hispanic population, while only 38 objectives had data needed to measure disparity faced by Native Hawaiian or Other Pacific Islander populations (U.S. DHHS, 2011a).
The Intercultural Cancer Council (ICC), an organization that disseminates information on cancer among Native Hawaiians and Pacific Islanders and cancer, found that these ethnic groups are socioeconomically disadvantaged and underserved (ICC, n.d.). Access to health and social services is lacking for Native Hawaiians and Pacific Islanders. The ICC (n.d.) cited access as an important factor in contributing to the disparity in mortality rates from cancer. Lack of cancer education programs, inadequate data collection mechanisms, and lack of cultural sensitivity of health care providers have been cited as factors contributing to the disparity in cancer care (ICC, n.d.). For most Pacific nations under U.S. jurisdiction, cancer databases are underdeveloped or do not exist at all (ICC, n.d.; Palafox, Yamada, Ou, Minami, Johnson, & Katz, 2004).

**Problem Statement**

The purpose of this study was to examine perceived barriers to health care among Chuukese migrant women in Guam and to examine what factors may be influencing health-seeking behaviors. An additional aim of the study was to identify interventions recommended by the Chuukese migrant women and key informant participants, which may reduce those perceived barriers to health care. Studies on the Chuukese people and health-seeking behaviors are also limited (Shoultz et al., 2007). Health care providers, policy makers, and government officials need more information in order to begin to understand and work towards improving the complex problem of disparities as it affects this population in Guam.

**Research Questions**

To gain insight into the perceptions of Chuukese migrant women regarding health and barriers to health care, the following research questions were proposed:

1. What barriers to health care are perceived by Chuukese migrant women and key informants in Guam?
2. What social, cultural, economic, and political factors are perceived by Chuukese migrant women and key informants that influence the health-seeking behaviors of Chuukese migrant women in Guam?

3. What recommendations for interventions do the Chuukese migrant women and key informants suggest to decrease the barriers to health care faced by Chuukese migrants in Guam?

**Summary**

The Chuukese migrants in Guam are increasing in numbers and in need of health care, education, and welfare services (Guam Bureau of Statistics and Plans, 2005, 2006; U.S. Department of the Interior, 2003). Data provide evidence that this population experiences health disparities at higher rates than the local population (Alur, Kodiyanplakkal, Del Rosario, Khubchandani, Alur, & Moore, 2002; Guam Bureau of Statistics and Plans, 2005; Salvation Army, 2005). Little is known about their perceptions of barriers to health care services or the cultural, social, economic, and other factors that may influence their health-seeking behaviors. This study aimed to increase the knowledge known about this ethnic minority and the understanding of the issue of health disparities. The research study added to the body of knowledge about the complex factors that influence health-seeking behaviors and about barriers to care among the Chuukese people in Guam. The information gained through this research can assist in the advancement of nursing practice in many arenas such as acute care, outpatient clinics, and community health settings. This knowledge can assist nurses, other health care providers, and policy makers in planning and implementing strategies to improve health care and health outcomes for this population.
Chapter 2

The issue of disparities in the United States entered the national spotlight at the end of the 1990s, when research reports revealed the existence of health disparities faced by minorities (IOM, 2003). As recognition and acknowledgement of the issue grew, there was a call for research to increase understanding of this complex problem (IOM, 2003; IOM, 2005). This review of literature will begin with a broad overview of the research on disparities in the United States and then describe the state of disparities among Asian American and Pacific Islander populations in the nation. A review of the literature of disparities among Micronesians including the Chuukese will be presented followed by a description of characteristics of Micronesian migrants in Guam relevant to the issue of disparities. The Vulnerable Populations Conceptual Model is presented as a guiding framework for this study. This model is population-focused with a community health perspective (Flaskerud & Winslow, 1998). Additionally, the concept of marginalization is discussed as a process that creates vulnerable populations; these vulnerable populations are at higher risk of suffering from health disparities (Meleis, 1996; Vasas, 2005).

Historical Overview of Disparities in the United States

During the end of the 1990s, a growing body of research studies revealed that racial and ethnic minority groups in the United States experienced higher rates of morbidity and mortality than did Whites (IOM, 2003; National Center on Minority Health and Health Disparities. 2001). Numerous studies demonstrated that minorities received lower quality of health care services and fewer routine services than Whites did even when differences in income and insurance were taken into account (Ayanian, Weissman, Chasen-Taber, & Epstein, 1999; Petersen, Shaw, DeLong, Pryor, Califf, & Mark, 1997). Ayanian et al. (1999) reported that Black patients were less likely than Whites to receive appropriate cardiac medications and that Black patients also
received lower quality of care than Whites did. Blacks were also less likely than Whites to undergo medical procedures such as angioplasty and revascularization (Petersen et al., 1997).

Research findings documenting health care disparity were a cause for concern to the U.S. Congress and in 1999, Congress requested that the IOM assess the types and quality of health care received by population groups across the nation (IOM, 2005). The IOM was charged with the task of assessing the degree to which disparities in health care exist that occur independently of patients’ insurance status, income, and other factors known to affect access to care; to evaluate potential causes of disparity including bias, discrimination, and stereotyping; and to make recommendations concerning measures to eliminate health care disparities (IOM, 2003).

As recognition of the problem of disparities in the United States increased, the reduction of health care disparities became a priority in the area of public policy. This led Congress to pass significant legislation in an effort to address the problem of disparities. Congress enacted Public Law 106-129, the Healthcare Research and Quality Act of 1999, and directed the Agency for Healthcare Research and Quality (AHRQ) to develop two annual reports: the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR). The focus of both reports is quality care for all and the intent is to provide a means of monitoring the progress made towards improving health care delivery in the nation (U.S. DHHS, 2003).

Another important piece of legislation is the Minority Health and Health Disparities Research and Education Act of 2000 (Public Law 106-525), which established the National Center on Minority Health and Health Disparities (NCMHD). The Act directed the center to serve as a focal point for planning and coordination of health disparities research. The legislation also required the Center to work with the National Institutes of Health (NIH) in developing a strategic plan for the reduction and eventual elimination of health disparities. The mission of the
NCMHD included efforts to identify all populations in the United States that experience disparities in health (NCMHD, 2001).

In 2002, the IOM issued its report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The IOM extensively cited disparities suffered by racial and ethnic minority groups. The report asserted that minorities receive a lower quality of care and that the causes of disparities are complex. The IOM reviewed more than 100 studies addressing racial and ethnic differences in a range of clinical procedures. A major finding was that racial and ethnic disparities exist and occur independently of income, education, insurance status, and other access-related factors. These disparities are extensive over a broad range of diseases and health care services and procedures. Additionally, these disparities often result in poorer health outcomes for these racial and ethnic groups. The IOM also documented that bias, stereotypes, and perhaps even prejudice, on the part of health care providers play a role in the lower quality of care given to minority groups. The IOM advocated for more research to gain a better understanding of the extent of disparities, and the impact on health outcomes for minorities in the U.S. (IOM, 2003).

The IOM cited many barriers that contribute to disparities. Among them are systemic problems involving health systems, health plans, patients’ attitudes and health-seeking behaviors that affect health care. The complexities of the health system, time constraints and financial issues also may affect the care received by minority patients (IOM, 2003). The IOM report received considerable media attention and served as a critical first step in dealing with the problem of disparities in health care. *Unequal Treatment* began to raise awareness of the problem among health care providers, patients, the general public, insurance companies, and federal and state policy makers (IOM, 2005).
In 2003, as mandated by the Healthcare Research and Quality Act of 1999, the Agency for Healthcare Research and Quality (AHRQ) published the first *National Healthcare Disparities Report* (NHDR). This first report provided a comprehensive overview of the state of disparities in the nation. The report highlighted the complex nature of disparities (U.S. DHHS, 2003). Many factors lead to health care disparities including genetic predisposition to illness, environment, lifestyle, culture, linguistic barriers, availability and accessibility of health care, trust in health care providers, seeking timely care, and health care practitioner beliefs (Harrison & Falco, 2005; IOM, 2002; U.S. DHHS, 2000, 2003). The 2003 *NHDR* (U.S. DHHS, 2003) tracked disparities in health care delivery related to racial and socioeconomic factors in subgroups identified by the Act as priority populations. The *NHDR* identified the priority groups as having unique health care needs or problems that necessitate special consideration and attention. The priority populations include low-income groups, women, children, disabled, those in need of end-of-life care, elderly, racial and ethnic minorities, children with special needs, and those in need of long-term care (U.S. DHHS, 2003).

Each year, the AHRQ has continued to publish reports on disparities and quality care. The *2006 National Healthcare Disparities Report* (U.S. DHHS, 2006) provided an overview of health care disparities affecting ethnic, racial, and socioeconomic population groups in the U.S. and reported on the progress made to reduce disparities. The 2006 report incorporated improved measures for summarizing quality and disparities in health care including trends in disparities (U.S. DHHS, 2006). The *2008 National Healthcare Disparities Report* (U.S. DHHS, 2009), continued to evaluate trends in disparities related to the quality of and access to care. The focus of the *2008 NHDR* was to examine the extent to which the nation is improving in its efforts to address disparities affecting priority populations (U.S. DHHS, 2009). The latest report, the *National Healthcare Disparities Report 2011* continued to document the existence of disparities
in health care. Approximately half of the measures for access to health care did not show improvement, and 40% of measures had declined. There was a 2.5% rate of improvement in quality measures overall; approximately 60% of measures had improved. These improvements included all ethnic, racial, age, and income groups tracked (U.S. DHHS, 2012).

**Review of Literature**

**Disparities Among AAPIs**

Disparities exist in many areas of health for members of the AAPI minority group (Ghosh, 2003; Louie, 2001, Palafox & Kaanoi, 2000). In the U.S., in 2007, the rate of tuberculosis (TB) cases for Whites was 1.1 per 100,000. The rate for Asians was significantly higher at 25.8 per 100,000. The rate for Native Hawaiian or other Pacific Islanders was also high at 23.4 per 100,000. The TB rates from 2006 to 2007 decreased for all ethnic groups except for Asians and Native Hawaiians or other Pacific Islanders (Pratt, Robison, Navin, & Menzies, 2008). The rate of esophageal squamous cell carcinomas among Asians and Pacific Islanders was 81% higher than the rate for Whites. The rate for Whites was 2.1 per 100,000 while the rate for Asians and Pacific Islanders was 3.8 per 100,000 (Wu, Andrews, Su, Chen, Ruiz, & Correa, 2006). The most recent statistics on poverty in the U.S. document higher rates for Asians than for Whites. The rate for Whites was 8.2%, while 10.3% of Asians were in poverty (DeNavas-Walt, Proctor, & Smith, 2007).

The wide variation in the AAPI subgroups results in major differences that influence health status. Vietnamese women in the United States suffer from cervical cancer at rates nearly five times the rate for White women. Native Hawaiians between the ages of 19 and 35 are more than five times as likely to suffer from diabetes as non-Hawaiians (in the same age range) (Asian & Pacific Islander American Health Forum [APIAHF], 2005). Unfortunately, there has been inadequate information on the subgroups within the AAPI designation. Data are often aggregated
or only address a few specific subgroups. The aggregated data are not useful in addressing the needs of this diverse minority group (Fong & Mokuau, 1994; Ghosh, 2003; Srinivasan & Guillermo, 2000). As this minority population increases, it will become critical to have meaningful information on the individual AAPI subgroups (Ghosh, 2003).

A significant step in the efforts to learn more about the AAPI subgroups occurred in July 2003 when the U.S. Census Bureau released disaggregated data on socioeconomic information for more than 21 different subgroups. The APIAHF reviewed and analyzed the data on six socioeconomic indicators that influence health status. These indicators include language, educational level, income and poverty, immigration and citizenship, health workforce, and other household measures. The APIAHF review provided the most comprehensive data available in the United States on socioeconomic indicators for these populations and revealed evidence of extensive differences within the AAPI minority population (APIAHF, 2005).

Some AAPI groups have relatively high levels of education and income; however, most of the subgroups continue to suffer from low educational achievement and high rates of poverty. For example, the aggregated data for Asians per capita income in 2000 was $20,719 (U.S. per capita income was $21,587). However, the disaggregated data reveals wide variations among the subgroups. The per capita income for the Hmong subgroup was $6,613 while Japanese per capita income was $25,576. The Hmong living below the Federal poverty line in 2000 was 38%, while the Japanese were 9% and the U.S. total living below the Federal poverty line was 12%.

This review of AAPI subgroups demonstrates the importance of disaggregated data in furthering the understanding of this diverse minority (APIAHF, 2005). The APIAHF recommends increasing data collection at the federal level including over-sampling and other statistical techniques in order to obtain a more accurate picture of the health and socioeconomic status of AAPIs (APIAHF, 2006).
Cancer has been identified as a significant area of disparity among AAPIs (Chu & Chu, 2005; Finlay, Joseph, Rodrigues, Griffith, & White, 2002; Louie, 2001). The literature of AAPIs in the United States highlights the disparity in cancer rates. Cancer is the leading cause of death for Vietnamese and Chinese. The rates of stomach cancer for Koreans is five times greater than that of the general population. Liver cancer is higher in frequency in most AAPI groups due to the incidence of Hepatitis B infections (Louie, 2001). The study of a national data set, the Healthcare Cost and Utilization Project Nationwide, revealed significant disparities among AAPI women. When compared with White women, AAPI women were among the youngest being hospitalized for breast cancer treatment and were also the youngest to die during hospitalization. AAPI women were, on average, 17 years younger at death compared with White women, dying at a mean age of 46.2 years. Researchers suggested that AAPI women sought care later and were in more advanced stages of the disease than White women. The researchers stated that a limitation of the study was that the sample did not reflect the actual percentage of AAPI women in the population (Polek, Klemm, Hardie, Wheeler, Birney, & Lynch, 2004).

Although cancer incidence is increasing for AAPI groups, screening rates are not improving. Chen, Diamant, Kagawa-Singer, Pourat, and Wold (2003) suggested that disaggregating data is essential to a better understanding of the specific needs of the various AAPI subpopulations. Further research is needed which must include adequate sample sizes and specific data on the subgroups among the AAPI population (Chen et al., 2003; Chu & Chu, 2005; Kwong, Chen, Snipes, Bal, & Wright, 2005). In the study by Chen et al. (2003), researchers also identified key factors affecting cancer screening. Lack of health insurance was a limiting factor in women for obtaining cervical cancer screening. Many of the AAPI groups had higher rates of being uninsured in comparison to Whites. Study findings revealed that significant disparity
existed in AAPI women receiving Pap smears even when adjusting for socioeconomic factors, demographics, and access variables (Chen et al., 2003).

The incidence of lung cancer is higher among Asian immigrants when compared with non-Asians (Finlay, Joseph, Rodrigues, Griffith, & White, 2002). In a 5-year retrospective case-control study, Asian immigrants with lung cancer were compared to non-Asians with lung cancer to determine if there were differences in presentation of the disease. The study revealed that Asian immigrants present with more advanced stages of lung cancer and have lower survival rates than non-Asians. Fifty percent of Asians presented with Stage IV lung cancer, but only 38.1% of non-Asians, and 23.8% percent of non-Asians presented with Stage I lung cancer but only 11.9% of Asians (Finlay et al., 2002). The median survival at 2 years was 15 months for non-Asians and 7 months for Asians. Researchers recommended further study to determine why Asian patients delay seeking treatment and what other factors may influence disease presentation in Asians (Finlay et al., 2002).

The annual cancer deaths are reported for Chinese, Filipinos, Japanese, Asian Indians, Koreans, Vietnamese, Native Hawaiians, and Samoans. Because of the small relative sizes of these AAPI groups, cancer mortality rates, which are calculated using population estimates, are available only when the U.S. census is conducted once every 10 years (Chu & Chu, 2005). Rates of cancer mortality from 1988 to 1992 were compared with cancer mortality rates from 1999 to 2001 for AAPIs. The overall cancer mortality rates for AAPIs declined during the periods compared. The total AAPI pattern of decline, however, masked actual increases in cancer mortality rates for specific AAPI subgroups. The AAPI subgroups whose cancer mortality rates increased include: Filipino males and females, Japanese females, and Native Hawaiian females. A comparison of the 1988 to 1992 rates with the 1999 to 2001 cancer mortality rates showed were increases in the mortality rates for lung, breast, pancreatic, ovarian, and colorectal cancers
for Filipino women. In Filipino men, rates increased in lung and liver cancers. Japanese females had increases in liver, lung, and pancreatic cancer. Native Hawaiian females had increases in lung, liver, pancreatic, breast, and cervical cancers. The predominant cancer for all AAPI groups is lung cancer and the number one cause of cancer deaths for all AAPI ethnic groups excluding Asian Indian women (Chu & Chu, 2005). The researchers did not suggest an explanation for the predominance of lung cancer among AAPIs.

In another study of Asian subgroups and cancer incidence and mortality rates, researchers reported that using an aggregated statistic for all Asians and Pacific Islanders in the United States did not provide an accurate assessment of the cancer burden among subgroups (Kwong, Chen, Snipes, Bal, & Wright, 2005). When data for cancer were aggregated, Asian/Pacific Islanders in California had the lowest cancer incidence and mortality rates when compared with Whites, Blacks, and Hispanics (Kwong & Wright, 2003; Kwong et al., 2005). These aggregated data do not, however, accurately characterize the cancer incidence and mortality among specific subgroups. The study did not compare cancer incidence and mortality rates between Asians and Whites. The purpose of the study was to provide a more detailed assessment of the cancer burden among Asian subgroups (Kwong et al., 2005).

In 2000, California had the highest population of Asian Americans in the United States (Kwong et al., 2005). A review of Chinese, Filipino, Japanese, Vietnamese, and Korean subgroups in California examined cancer incidence and mortality patterns. Cancer incidence and mortality rates varied widely among the Asian subgroups. Among the subgroups studied, Vietnamese had the highest incidence rates for liver, lung, and bronchial cancers. The Vietnamese incidence rate for liver cancer was 33.3 per 100,000. In comparison, Japanese had the lowest incidence rate for liver cancer at 7.4 per 100,000. The Vietnamese incidence rate for cancers of the lung and bronchus was 51.6 per 100,000. This is much higher than the lowest
incidence rate (33.9 per 100,000) reported for Japanese. The cancer mortality rate was highest for Koreans (146.1 per 100,000) and lowest for the Filipino subgroup. The cancer mortality rate for Filipinos was 117.2 per 100,000. Female breast cancer mortality rates, however, were highest among Filipinos (17.3 per 100,000) when compared to the other subgroups. Koreans had the lowest mortality rates for female breast cancer (7.6 per 100,000). In California, cancer was the leading cause of death for Asian-American women, but statistics revealed that they are the least likely ethnic group to be diagnosed with cancer (California Department of Health Services, 2003a; Kwong et al., 2005). Cancer screening rates were the lowest for Asian-Americans than for any other ethnic group (when compared with Whites, Blacks, and Hispanics) in California (Kwong et al., 2005; California Department of Health Services, 2003b).

The incidence of certain subsite and histology-specific esophageal and gastric cancers has been documented at higher incidences in AAPIs compared with Whites. The rate of esophageal squamous cell carcinomas was 81% higher for Asians and Pacific Islanders than the rate for Whites. The rate for Whites was 2.1 per 100,000 while the rate for Asians and Pacific Islanders was 3.8 per 100,000 (Wu et al., 2006). The rate for gastric cancer for AAPIs was 21.3 per 100,000; this is slightly more than double the rate for Whites (10 per 100,000). Many factors, such as tobacco and alcohol use, positive family history, and high intake of smoked or pickled foods, have been associated with esophageal squamous cell carcinoma. The researchers stated, however, that there has not been adequate research to explain how different risk factors contribute to increased incidence rates based on ethnicity. They recommended that more research be conducted to better understand the possible reasons for differences in esophageal and gastric cancers among Asians (Wu et al., 2006).
Disparities Among Micronesians

A review of literature on health disparities among Micronesians showed a dearth of information. There is limited but growing research on AAPI populations; however, there are knowledge gaps in subgroups of the AAPI category (Ghosh, 2003; Louie, 2001). The current literature lacks information about many of the Asian American/Pacific Islanders groups. More information is needed to assist in efforts to improve care and outcomes for these populations (Ghosh, 2003; Louie, 2001; Shoultz et al., 2007). More research will result in increased knowledge about understudied groups, such as the Chuukese and other Micronesian groups.

Information on the health status of Micronesians in Hawaii was also limited; however, there are some data that suggest there are significant problems with chronic diseases such as diabetes, obesity, cardiovascular diseases, and cancers associated with lifestyle choices. The Hawaii Primary Care Association reported essential hypertension and diabetes mellitus as the top two reasons for patient visits among the Micronesian population (Pobutsky et al., 2005). In 2007, Micronesian migrants in Hawaii reported diabetes mellitus as the highest reported medical condition among adults over 40 years of age (Pobutsy, Krupitsky, & Yamada, 2009). Additionally, there are concerns in Hawaii regarding communicable diseases among Micronesians. The Hawaii Department of Health Tuberculosis Control Branch (as cited in Pobutsky et al., 2005) reported 5-year trend data (from 1998 to 2003) indicating 61 of 65 new cases of tuberculosis from Pacific jurisdictions came from the FAS.

The WHO Western Pacific Region encompasses 37 countries. The Republic of the Marshall Islands, the FSM, Guam, CNMI, New Zealand, Australia, American Samoa, Palau, and the Philippines are some of the nations included in this region. Leprosy had been a public health problem in the region and in 1989, the WHO adopted a resolution to achieve global elimination (prevalence rate of less than one case per 10,000 population) of leprosy by the year 2000. In the
Western Pacific Region, 35 countries had reached the goal of elimination by the end of 2000. For two countries, however, the FSM and the RMI, leprosy remains at levels higher than the goal (WHO, 2003). Leprosy, also known as Hansen’s disease, is a chronic bacterial infection that is not highly transmissible, although the disease has been feared as a highly contagious disease. It primarily affects the skin, peripheral nerves, and upper airway. Hansen’s disease is responsive to treatment and with early detection, it is not disabling (U.S. DHHS, n.d.).

Hansen’s disease is a concern in Hawaii because it is endemic in Micronesia. The majority of new cases of Hansen’s disease are diagnosed in Micronesians. The first case of Hansen’s disease in the Micronesian born population in Hawaii was in 1988. Since 2003, the number of Micronesian cases has grown and accounts for 80% of all new cases diagnosed annually. In a 10-year period, from 1994 to 2003, new cases in Micronesians included 97 patients. The state total of Hansen’s disease cases was 187 with Micronesians accounting for 52% of the total in the state (Hawaii Department of Health, 2004). Hansen’s disease prevalence rates in 2001 were highest in the RMI with 9.45 cases per 10,000. The FSM is second highest with prevalence rates of 4.96 cases per 10,000 (World Health Organization, 2003). The prevalence rate in 2001 for Hawaii was 0.19 per 10,000. This illustrates the endemic nature of Hansen’s Disease in Micronesia and the potential concerns for Hawaii due to the migration of Micronesians from the FSM and RMI (Hawaii Department of Health, 2004).

Haddock and Naval (2002) reviewed death certificates in Guam and found a high proportion of cancers in Micronesians in Guam (85.2 per 100,000). Indigenous Chamorros also had a high overall death rate from cancer (84.4 per 100,000). Lung cancer accounted for one third of all cancer deaths (Haddock & Naval, 2002). In a more recent study by Haddock, Talon, and Whippy (2006) cancer mortality statistics in Guam were reviewed for the period from 1998 to 2002. Findings revealed that Micronesians had the highest mortality rate for liver cancer (43.5
deaths per 100,000) among all ethnic groups in the study. The mortality rate for liver cancer is significantly higher than the U.S. liver cancer mortality rate of 4.9 deaths per 100,000. The study included the following ethnic groups: Chamorro, Black, White, Asian, and Micronesian ethnic groups. Chamorros had high mortality rates for mouth and pharyngeal cancers (9.1 per 100,000) when compared with the U.S. mortality rate (0.2 per 100,000). Chamorros also had high rates of nasopharyngeal cancer (9.1 per 100,000). This rate is much higher than the U.S. mortality rate of 0.2 per 100,000 for nasopharyngeal cancer (Haddock, Talon, & Whippy, 2006).

Haddock, et. al; (2009) reported on cancer incidence among residents of Guam. Incidence data collected from 1998 to 2002 through the Guam Cancer Registry were analyzed, revealing ethnic disparities in cancer incidences. Micronesians other than Chamorros had the highest age-adjusted incidence rates of cervical cancer. The incidence rate for Micronesians was 27.4, 16.2 for Chamorros, and 8.5 for Asians per 100,000 population. These rates compare with the U.S. incidence rate of 9.6 per 100,000. The disparity among Micronesians is significant. The data on liver cancer incidence are also significant. The rate for Micronesians was 39.4, for Chamorros 13.2, and for Asians 10.6 per 100,000 population. The U.S. incidence rate for liver cancer was 5.2 per 100,000 population. Incidence rates for breast, colon, and prostate cancer were lower than the U.S. rate. Another area of concern is cancer of the lung and bronchus. The U.S. incidence rate was 70.1 per 100,000, while the rate for Chamorros was 75.4 and 111.5 per 100,000 for Micronesians (Haddock, Whippy, Talon, & Montano, 2009).

The literature is scarce when examining the health of Micronesians in the United States. Pinhey and Millman (2004) studied AAPI adolescent sexual orientation and suicide risk in Guam. This study found that same sex orientation significantly increased the risk of committing suicide. A physically abusive relationship, hopelessness, and binge drinking were linked to increased risk of suicidal ideation. Although risk for suicidal ideation among boys was not
statistically significant, it was higher for Micronesians than for the other ethnic/racial groups (Whites, Filipinos, and Asians) in the study (Pinhey & Millman, 2004).

Alur, Kodziyanplakkal, Del Rosario, Khubchandani, Alur, and Moore (2002) documented the prevalence and morbidity of infants of diabetic mothers in Guam. The prevalence rates of gestational diabetes are higher for Micronesians than for non-Micronesians (5% vs. 3.7% respectively). The authors suggested that one reason for the high incidence among Micronesians is the lack of prenatal care or the receipt of late prenatal care. The incidence of gestational diabetes in the U.S. general population is 2.9%; for Micronesians in Guam, the incidence is 5%. The pregnancies complicated by diabetes resulted in higher risk for cesarean deliveries; 39% compared to 22.6% of the total live births in Guam and 23.6% of total live births in the mainland U.S. (Alur et al. 2002).

The cost of caring for infants born to diabetic mothers is significantly higher. The researchers estimated that the lowest possible cost incurred during the 30-month study period was $815,837.28 for 332 infants. This does not include an additional 22.7% cost above the expenditures for normal newborn hospital care. Approximately two-thirds of the infants born to diabetic mothers required longer hospital stays than those born to non-diabetic mothers. The highest incidence of large-for-gestational age infants was among the Chuukese. Micronesian infants of diabetic mothers were at higher risk for cesarean birth, large for gestational age, oxygen use and ventilator dependency as compared to non-Micronesian infants of diabetic mothers (Alur et al. 2002).

Of the 3,427 total births in Guam in 2004, 7.2% of mothers did not receive any prenatal care. Among the 7.2% who did not receive any prenatal care, however, 46.8% were from the FSM, representing the highest racial group lacking prenatal care (Guam Bureau of Statistics and Plans, 2005). There were 658 births to mothers from the FSM in Guam; 17.8% of those mothers
did not receive prenatal care. Percentages lacking prenatal care are similar for Palauan and Marshallese mothers (Guam Bureau of Statistics and Plans, 2005). The data are aggregated for all FSM mothers and do not provide specific data for the Chuukese. Infant mortality in Guam was 11.3 per 1,000 live births in 2003 (Guam Bureau of Statistics and Plans, 2005). This infant mortality rate contrasts sharply with the U.S. rate of 7.0 per 1,000 live births in 2002 (U.S. DHHS, 2005b; NCHS, 2006).

A limited number of studies have specifically addressed the perception of barriers to health services by an FAS ethnic group. The literature reviewed revealed only five studies that focused on health-seeking behaviors of Chuukese or other FAS ethnicities. Two of the five studies specifically addressed barriers faced by Marshallese in the United States. A study of Marshallese immigrants in the United States was conducted with the purpose of identifying socioeconomic and cultural barriers to health services as perceived by this immigrant population in Arkansas. Based on the findings, researchers made recommendations to improve care to this population. The Marshallese immigrants are part of the AAPI population in the United States. The fastest growing groups of Marshallese are located in Northwest Arkansas and experience adverse health outcomes and disparities, largely attributed to their premigration health status. The current literature of AAPIs does not adequately address the Marshallese. Marshallese are different from other AAPI groups due to their unique political, economic, and sociocultural factors. There is a lack of morbidity and mortality data to establish their health status in the United States. The goal of the study was to uncover the barriers as perceived by the Marshallese and identify methods to decrease those barriers (Williams & Hampton, 2005).

The study by Williams and Hampton (2005) was an ethnographic study. The participants reported ethnocultural barriers such as trust, modesty, language and communication difficulties, and cultural beliefs regarding health. Socioeconomic barriers reported by the Marshallese
included financial barriers such as lack of insurance, lack of knowledge regarding available resources, and systemic problems such as issues with immigrant status and the complexities of dealing with the American health care system (Williams & Hampton, 2005).

Another study of the Marshallese in the United States was conducted with migrants in Hawaii. The number of Marshallese in Hawaii has grown dramatically since the Compact of Free Association in 1986, and researchers conducted a qualitative study to gain insight into health-seeking behaviors of Marshallese migrants in Hawaii. Researchers conducted interviews with Marshallese migrants, key informants who were leaders in the Marshallese community, and health and social service providers experienced in working with Marshallese migrants. Three important themes describing the health-seeking behaviors of the migrants in Hawaii emerged from the data. The themes were that the health-seeking of Marshallese migrants in Hawaii is guided by their perception of a present health crisis, dependent on their migrant network, and reliant on public assistance and the Western health care system rather than homeopathic or traditional Marshallese medicines (Choi, 2008).

Marshallese migrants were not likely to seek health care until a crisis occurred. A health crisis was perceived when the magnitude of pain was no longer bearable. Marshallese perceived health as the absence of pain or discomfort, and when pain was no longer tolerable, they sought health services. If the pain or discomfort became tolerable, then they would not likely continue or follow up with health care provider recommendations or treatments. This led to a perception by health care providers of the Marshallese as non-compliant. The present crisis orientation to health-seeking was evident in the belief that preventive health care was not needed. Marshallese valued the tolerance of physical pain, leading migrants to accept their symptoms rather than seek medical care (Choi, 2008).
Marshallese migrants in Hawaii relied heavily on their migrant networks for obtaining health care. These networks, which included extended family, church members, and Marshallese co-workers, reinforced the cultural norms and provided emotional and financial support to migrants. These networks served as lay referral systems and influenced when and where Marshallese sought health care. The availability of their support systems to take them to health care appointments or even to seek health care services highly influenced use of health care. The individual’s need for health services was not the driving force; rather, the ability/availability of networks was the key to seeking care, unless the situation was an extreme emergency (Choi, 2008).

The third theme identified was the concentration on public assistance and allopathic health care. Although Marshallese migrants reported traditional views regarding health and illness, they were not likely to use traditional Marshallese medicines or treatments. The migrants relied exclusively on the Western health care system. Participants identified a preference for Western care and weak beliefs in the usefulness of traditional medicines. The reliance on Western health care may be influenced by the lack of availability of Marshallese traditional medicines in Hawaii and the self-selective migration to Hawaii in pursuit of Western medical treatment by many migrants. Marshallese migrants heavily used public health centers rather than private clinics, as a majority were insured by the state health insurance plan. The public health facilities were identified as more accessible, affordable, and available for the migrants. They reported a high level of familiarity with public health facilities, and these facilities are more likely to have bilingual staff. This study revealed patterns of cultural beliefs and behaviors affecting the health-seeking of Marshallese migrants in Hawaii. These findings are important, adding to the understanding of Marshallese migrants. The findings are particularly relevant in the areas of community health practice and policy (Choi, 2008).
The literature included several studies conducted with migrant communities in Hawaii. Two studies addressed cancer screening among Chuukese women in Hawaii. Wong and Kawamoto (2010) identified barriers to cervical cancer screening among Chuukese women. The purpose of the study was to describe the knowledge, attitudes, and beliefs regarding cervical cancer screening by Chuukese women in Hawaii. Researchers cited the lack of literature about the health beliefs of Chuukese women and the need to conduct research and gain knowledge to inform future research and development of interventions to increase cervical cancer prevention. Cervical cancer was listed as the primary cause of cancer deaths among women in Chuuk; however, no statistics were provided. Women identified as key informants within the Chuukese community in Hawaii were interviewed. All women had leadership roles within a Chuukese women’s group or Church group (Wong & Kawamoto, 2010).

The main barrier cited by women for not obtaining Pap smears was that women did not want to expose their “private parts” to anyone. Women also indicated that their husbands did not want another male to look at their “private parts” and would not give consent to the wife. Women also described fear of the diagnosis, fear of the unknown, and shame in having a Pap smear (due to exposure of the genital area) as barriers to screening. The women recommended education as a means of increasing Chuukese women participation in cervical cancer screening. The women expressed the importance of educating Chuukese men and women. Educating both the husband and wife is critical in order for the woman to obtain the husband’s consent to receive a Pap smear (Wong & Kawamoto, 2010).

The second study addressing cancer screening was also conducted in Hawaii. This qualitative study was designed to identify barriers to screening for breast and cervical cancer among Chuukese, Marshallese, Filipina, and Hawaiian women (Aitaoto, Tsark, Tomiyasu, Yamashita, & Braun, 2009). Researchers conducted focus groups and key informant interviews.
Five common barriers were reported across ethnic groups. These included limited understanding of breast and cervical cancer, lack of transportation, competing priorities, cultural beliefs impacting health-seeking behaviors, and fear of bad news. Competing priorities included the need to care for family members such as children, ill relatives, and elderly parents; the need to work more than one job; and church and social obligations. Women described cultural influences on health-seeking to include a group-orientation that would make a woman more likely to seek help if she could do so as part of a group, and that women preferred to bring an advocate with them to appointments. Sources of health information were most often family or community gatherings, trusted leaders and relatives, with health care providers and print media as the least likely sources of information (Aitaoto et al., 2009).

The Micronesian women in the study described a need for health information to be given through trusted community sources. The Chuukese and Marshallese reported trusted and respected community leaders or relatives as their main source of health related information. Only 25% of Chuukese and Marshallese participants reported print media and radio were reported as sources of health information. None of the Chuukese and Marshallese women in the study cited television as a source; this contrasted dramatically with the Filipina (100%) and Hawaiian (53%) participants (Aitaoto et al., 2009).

Key informants were community outreach staff working with Hawaiian, Filipina, Marshallese, or Chuukese women. They described the Marshallese and Chuukese women as a highly transient group with many financial struggles. The women were low income, living in overcrowded housing, and responsible for the caretaker roles in the family. The financial and social stressors kept them from seeking help. Key informants identified the inability to understand and speak English as a major barrier. Providers also reported difficulty working within the cultural norms of the Micronesian women. The researchers identified difficulties due
to the group orientation of the cultures. Recommendations were made to develop culturally appropriate strategies to increase breast and cervical cancer screening among these ethnic populations. Outreach and infrastructure changes were recommended to facilitate women’s health-seeking and increase the number of women obtaining screening services (Aitaoto, Tsark, Tomiyasu, Yamashita, & Braun, 2009).

There was one study of Chuukese migrant women and intimate partner violence (Shoultz et al., 2007). This qualitative study used the focus group method to examine the views of Chuukese migrant women in Hawaii on intimate partner violence (IPV). The study cited the Compacts of Free Association and the resultant increases in the Chuukese migrant population in Hawaii. No statistics were provided regarding prevalence of IPV among Chuukese; however, the increasing numbers of Chuukese being served at various Hawaii community health centers prompted the research team to examine the cultural perceptions, awareness, and actions regarding IPV by Chuukese women. Findings from the study revealed that migration resulted in multiple socioeconomic challenges such as poverty and unemployment. The cultural expectations of Chuukese women also placed them at risk when faced with IPV. The women identified the cultural role of women as family peacekeepers as a barrier to seeking help. The loss of cultural ties and the support of the extended family contributed to risk for women who experienced IPV. The women discussed the support traditionally given to them by their sisters and mothers in Chuuk. With migration, this support may not be present. The researchers made recommendations for further research, as well as the development of screening tools and interventions from the cultural perspective of the Chuukese women (Shoultz et al., 2007).

The researchers who conducted the IPV study with Chuukese migrants also investigated IPV among other Pacific Islander groups: Native Hawaiian, Filipino, and Samoan. Common themes emerged from a comparison of the findings from each ethnic group: living within a
collective, cultural protective factors, cultural barriers to help seeking, gender specific roles, and belonging to a place. All four ethnic groups identified the importance of the extended family, the clan, and the community. Women described the importance of the group rather than a focus on the individual. In Chuuk, the chief provides guidance and assistance, but the church pastor has assumed this role for many Chuukese in Hawaii. In situations of IPV, the family provided protection for women in Samoan and Chuukese cultures. Historically the clan, community leaders, and the family provided mechanisms for women who had been abused. Women could seek shelter with family members who also provided support for their children and a break from the abusive situation (Magnussen, et al., 2011).

Researchers identified cultural barriers common to the four cultural groups, including the expectation to remain in the relationship despite the abuse. Chuukese and Samoan women often avoided discussing the abuse for fear their male relatives would seek revenge on the husband. Chuukese and Samoan men are honor bound to protect and defend their female relatives. Gender roles affected help seeking for all four cultural groups. Chuukese, Filipino, and Native Hawaiian women expressed their role as peacemaker in the family and the concern for the welfare of the children as barriers to help seeking. Chuukese women related their role duty to keep the peace and preserve family honor. All ethnic groups described the importance of belonging to their country of origin. The immigrant participants described the disruption caused by the move to Hawaii and the loss of the cultural protective factors. For Chuukese, the loss of the importance of their land, and the loss of the communal environment negatively affected the women (Magnussen et al., 2011).

The researchers expressed a concern that identification, assessment, and treatment of IPV may be more difficult and less effective in diverse Pacific Islander populations when using traditional Western-based screening and treatment approaches. They recommended development
of culturally sensitive screening tools and planning interventions based on the cultural perceptions of the women. Participants in the study recommended that staff who are members of the same cultural group be available to work with women facing IPV. Researchers advocated for community involvement in prevention, education, and intervention strategies (Magnussen et al., 2011).

Characteristics of Micronesian Migrants in Guam

Population

The population of Guam in 2000 was 154,805, including 10,971 from the Freely Associated States. The FSM migrants from the islands of Chuuk, Pohnpei, Kosrae, and Yap comprise the largest group at 8,573. There were 257 from the RMI, and 2,141 from the ROP. The vast majority of the FSM migrants came from Chuuk. Chuukese comprised 72.7% of the FSM population in Guam and 56.7% of the total FAS population in 2000 (Guam Bureau of Statistics and Plans, 2005).

In 2004, the total Guam population was 166,090 with 11,779 from the Freely Associated States: 9,165 from FSM, 322 from RMI, and 2,292 from ROP. The FAS migrants account for 7% of the total Guam population. The Chuukese continue to comprise the largest of the FSM migrant population on the island, with a population of 6,659, approximately 72.6% of the total FSM migrant population on Guam. Based on the census data in 2004, the majority (approximately 56.5%) of the FAS migrants were from Chuuk (Government of Guam, 2005).

Socioeconomic Characteristics

In 2003, data were compiled regarding the characteristics of the FAS populations in Guam, Hawaii and the CNMI. According to the data, in Guam, 5.7% of the FAS Impact population speak only English at home; 94.3% report speaking a language other than English at home; of those, 76.5% report speaking the other language more frequently than English. Data for
the Chuukese in Guam are available with 2.3% reporting that they speak only English at home, while 97.7% speak the other language more frequently than English (U.S. Department of Commerce, 2003).

In terms of economic status, in 2002, 46.3% of the FAS population lived below the poverty level (U.S. Department of Commerce, 2003). The data specifically for the Chuukese were not reported. The 2002 poverty rate in the United States was 12.1% (DeNavas-Walt, Proctor & Mills, 2004). The median household income in Guam was $40,877. The 2002 median household income for FAS migrants in Guam was $21,715 (U.S. Department of Commerce, 2003). This compares to the U.S. median household income of $43,318 in 2002 (DeNavas-Walt, Proctor & Mills, 2004).

The median household income for Chuukese in Guam was $18,099 in 1999. The median household income for the total population in Guam in 1999 was $39,317. For that same year, the percent of Chuukese families living below the poverty level was 62.6, compared to the total population living below the poverty level at 20% (Guam Bureau of Statistics and Plans, 2005). As a means of comparison, for the same year, 1999, the U.S. poverty rate was 11.8% (U.S. Department of Commerce, 2003). The median household income in the U.S. was $42,148 (U.S. Department of Commerce, 2001b).

The most current available data from 2003 for Impact migrants do not include a breakdown for Chuukese. The Chuukese migrants were included in the Federated States of Micronesia (FSM) category. The 2003 data for migrants from the FSM living in Guam reported the median household income of $21,715. The median household income for the total population in Guam in 2003 was $33,457. For that same year, the percent of FSM migrant families living below the poverty level was 45.2 % (Guam Bureau of Statistics and Plans, 2011). Data for 2003
were not reported for the total Guam population living below the poverty level. The U.S. poverty rate for 2003 was 12.5% (DeNavas-Walt, Proctor, & Mills, 2004).

In terms of socioeconomic issues, additional characteristics of Chuukese, and the FSM population in general, should be highlighted. In 2005, the Salvation Army conducted a count of the homeless in Guam. Those homeless who reported Chuukese ethnicity for the head of household made up 15.71% of the homeless population (Salvation Army, 2005). In 2007, those who reported Chuukese ethnicity for the head of household accounted for 16.26% of the homeless in Guam (Salvation Army and Guam Housing and Urban Renewal Authority, 2007). Chuukese ranked second in number of homeless by ethnicity in both of the recent homeless surveys (Salvation Army and Guam Housing and Urban Renewal Authority, 2007).

The Guam Police Department (as cited by Guam Bureau of Statistics and Plans, 2005) recorded the following crime statistics for Chuukese in 2003: 33.8% of arrests for driving under the influence of alcohol, 52.9% of arrests for drunkenness, and 36.5% for aggravated assault arrests. According to the Salvation Army (2004), although Chuukese comprised approximately 5% of the total Guam population, they accounted for 50% of arrests for drunk driving and 50% of arrests for assault. The Salvation Army Family Services Center reported that 80% of their clients were Chuukese (Salvation Army, 2004).

Living Conditions

The Salvation Army (2004) conducted a detailed needs assessment of residents living in an area known as “88 Lots” and the adjoining “Gill Baza” subdivision in the northern village of Yigo. It was difficult to obtain accurate population counts in the area, but the Salvation Army estimated that approximately 600 people live in the area. From this survey, the average household size was noted to be 7 to 8 people. The majority of the residents were Chuukese (77.6%). The report highlighted major concerns of residents in this area. The most common
concern raised was the condition of the unpaved gravel roads leading into and running throughout the area. The treacherous conditions greatly affect many aspects of their daily lives. The heavy rains cause huge potholes, resulting in heavy wear and tear on vehicles, leading to a need for frequent maintenance. The children often miss school because the bus stop is extremely far away and at times, they cannot get through the mud and rain. Drivers of emergency vehicles are reluctant to enter the area, and residents complain that police and other first responders will not come because of the road conditions (Salvation Army, 2004).

Utilities are a major issue and are not available to all residents. Phone service is non-existent, and the sewage system is inadequate, with many homemade systems in the area. Many residents cannot afford to apply for electricity and water, even when the utilities are available to the properties. Therefore, the majority of residents live without running water or electricity. These conditions affect their ability to obtain education, seek employment, and improve their situation (Salvation Army, 2004, p. 7). Schools have reported that students from these subdivisions come to school in an unclean condition because they cannot take showers or bathe. When heavy rains flood the roads, students cannot go to school, and adults miss work as well (Flores, 2005). An important realization of the Salvation Army Social Worker conducting the surveys in these subdivisions was that the residents of this area “seem to live in a different world than the rest of the island. The majority of people on the island are not even aware of the existence of such conditions so close to their own homes” (Salvation Army, 2004, p.7).

The sanitation problems pose definite health threats to the children and families living in these subdivisions. Two Micronesian children, residents of the Gil Baza subdivision, presented in the emergency room of the Guam Memorial Hospital in July 2005. Both children were found to have an intestinal parasitic infection, *Asaris lumbricoides*. The hospital’s chief pathologist, Dr. Phil Dauterman, described the situation in dire terms: “You basically had people there who were
drinking raw sewage” (Flores, 2006, p. 22). *Ascaris lumbricoides* is rare on Guam, but common in developing nations. The territorial epidemiologist reported the matter to the Guam Environmental Protection Agency (GEPA) for further investigation. The GEPA inspected the subdivision of “Gill Baza” and found violations due to the lack of sewer lines (Flores, 2006).

Another subdivision in which many migrants live is “Zero Down,” in the northern village of Yigo and a jungle region. Two developers own the property, which contains almost 200 quarter-acre lots. Most of the residents are from the FSM, with the majority being Chuukese. The developers promised infrastructure improvements, including septic tanks, electricity, and water. Many of the structures in the area are wood and tin (Flores, 2005). The GEPA also investigated this subdivision after the *Asaris lumbricoides* incident in July 2005 and found similar violations of building, health, and safety codes (Flores, 2006).

The road conditions in these subdivisions are deplorable, and garbage trucks cannot get into the area. Trash is piling up in the neighborhood, including broken appliances, refrigerators, mattresses, and abandoned vehicles. Police and emergency vehicles as well as buses cannot access the area. The school bus stop is almost a mile and a half away from the neighborhood. Many miss school when the rains create huge, impassable holes in the road, sometimes referred to as “rivers” by the residents. Residents reported feeling taken advantage of because of the perception that they will not complain (Flores, 2005).

The residents also reported a sense that their needs were ignored because they do not have political influence (Flores, 2005, 2006). Citizens of the FAS are non-immigrant aliens (Government of Guam, 2005). Residents of “Gill Baza” and “Zero Down” complained that they have little voice in government and politics due to their status as non-citizens. They do not have voting rights in Guam. They are frustrated at the lack of improvement, and there is an ongoing lawsuit filed on behalf of the residents against the land developers by the United Pacific Islander
Corporation (UPIC). The organization was incorporated in 2005 and continues to work to resolve the sewage issue. Residents are hoping the developers will be required to install sewer lines and correct GEPA violations (Flores, 2005).

There are few studies of Chuukese migrants and perceptions of barriers to health care or of factors affecting health-seeking behaviors. More research is needed to increase the knowledge base of the Chuukese (Shoultz et al., 2007). This study used a qualitative approach to discover, examine, and increase understanding of this migrant group in Guam. Qualitative research allows one to describe and explore the social world (Morse & Field, 1995). The goal of qualitative research was to gain understanding from the perspective of the participants and explore assumptions and attitudes underlying behaviors within the context in which they occur (Morse & Field, 1995). The qualitative method was appropriate for the focus and purpose of this study. The qualitative method allowed the researcher to explore perceptions and behaviors from the perspective of the Chuukese women participants within the context of their lives in Guam.

**Conceptual Model**

**Vulnerable Populations Conceptual Model**

The Vulnerable Populations Conceptual Model (VPCM) is a population-focused model with a community health perspective. Vulnerable populations are defined as “social groups who experience limited resources and consequently high relative risk for morbidity and premature mortality” (Flaskerud & Winslow, 1998, p. 60). In the model, the constructs of resource availability, relative risk, and health status are interrelated (see Figure 1). Resources include socioeconomic and environmental resources such as health care quality, differential access to care, income, education, housing, social supports, social status, and employment. A lack of resource availability increases one’s relative risk. Resources strongly influence one’s ability to avoid risk and minimize disease and its consequences (Flaskerud & Winslow, 1998).
Relative risk involves the exposure to risk factors such as behavioral and lifestyle choices (dietary behaviors, weight, physical activity), health-promoting behaviors (immunizations, screening), and injury prevention (firearm use, safety belt use, drinking and driving). Relative risk is the ratio of risk of poor health for those who do not have adequate resources and are exposed to risk factors compared to those who do have resources and are not exposed to risk factors. This relative risk interacts with health status; increased risk leads to increased morbidity and mortality in the vulnerable population (Flaskerud & Winslow, 1998).

Health status interacts with resource availability; increased illness and death may feed back into resource availability and drain the available resources. Nursing research, policy analysis, and nursing practice have the potential to affect resources, risk, and health status by intervening in the relationships among the model components (Flaskerud & Winslow, 1998).
Vulnerable populations are at higher relative risk of experiencing adverse health outcomes such as increased morbidity and premature mortality. Vulnerable populations often include immigrants, ethnic minorities, the homeless, women, children, the elderly, gay men, and lesbian women. These groups experience limited socioeconomic and environmental resources that influence their health outcomes. Socioeconomic resources include education, income, employment, housing, lack of family and social supports, and low social status. Research has supported the link between these socioeconomic and environmental resources and health outcomes (except in the area of access to care). Access to health care is an area needing further research in terms of health outcomes (Flaskerud & Winslow, 1998).

The Chuukese migrants in Guam are a vulnerable group. The limited socioeconomic and environmental resources are evident in the high poverty rates, lower education and income levels, and substandard living conditions. Lack of resources may influence their ability to decrease their relative risk leading to morbidity and mortality. The ability to prevent injury and develop health promoting behaviors is limited by a lack of environmental and societal resources (Flaskerud & Winslow, 1998). This study elicited information regarding barriers faced by Chuukese women in Guam and the factors that affected their health-seeking behaviors. Recommendations for interventions to decrease these barriers and improve care for Chuukese migrants were received from the Chuukese women participants and from the key informants. These recommendations were useful in guiding research, practice, and policy decision-making and analysis.

The VPCM provided a guiding framework for this study. The community health focus was an appropriate perspective to use when researching the issue of health barriers and factors influencing health-seeking behaviors. Research with Chuukese participants may yield pertinent information about resource availability, risk factors, and health status as it pertains to this
migrant group. How the model components manifest among this population group is important, and information may be learned that can prove useful in developing interventions that may positively affect their health care. The VPCM proposes that nursing can influence resource availability, relative risk, and health status both directly and indirectly, through nursing research, practice, and policy analysis (Flaskerud & Winslow, 1998). The results of the study contributed to the knowledge base of those working to provide health care services to this population and give guidance to those who can act to improve their health status.

**Marginalization**

In addition to the VPCM, this study proposed an even broader perspective from which to frame and examine the possible causes for this vulnerability. What makes a group more vulnerable? An important concept to consider in relation to vulnerable populations is marginalization. The process of marginalization creates vulnerable populations that are at higher risk of suffering from health disparities (Meleis, 1996; Vasas, 2005).

The literature on marginalization refers to exclusion and isolation of the marginalized population from the dominant group or the Center; the marginalized group is referred to as the Periphery (Hall et al., 1994). The boundaries that exist exclude and isolate the marginalized from the mainstream (Burton & Kagan, 2005). Through the process of marginalization, these populations are placed on the periphery of the dominant society. Marginalization leads to isolation and social exclusion, creating vulnerable populations. Through an understanding of the process, nursing has the potential to contribute to the reduction of health disparities. Recognition and understanding of the concept of marginalization is vital to the issue of health disparities (Vasas, 2005).

In examining perceptions of the Chuukese, this study began to uncover the factors contributing to marginalization of this population group. Marginalization contributed to
increased vulnerability of populations with subsequent increased exposure to health risks (Vasas, 2005). Factors affecting Chuukese migrants in Guam included higher rates of poverty, geographic isolation within substandard housing developments, linguistic and cultural isolation, and lack of power or voice in the mainstream society. These factors influenced the lives of the Chuukese and contributed to the process of marginalization.

Vasas (2005) asserted that social marginalization occurs through geographic isolation. Geographic isolation places people far away from needed resources such as food, water, and schools (Vasas, 2005). Several large Chuukese neighborhoods, such as the “Zero Down” and “Gill Baza” subdivisions described earlier, are examples of geographic conditions contributing to marginalization. The lack of resources such as electricity and running water, as well as the inaccessibility due to hazardous road conditions, are factors contributing to isolation, humiliation and powerlessness of this migrant group. One resident of “Zero Down” commented that many of the FSM citizens have jobs, but they cannot vote in Guam. They are not U.S. citizens and this inability to vote gives them little voice in efforts to persuade the government to improve the infrastructure or change laws so that these substandard conditions would no longer be allowed (Flores, 2005). Efforts are underway in the Guam legislature to change laws preventing developers from creating substandard housing situations. Legal battles are being fought in the courts to force the developers to rectify the situation and improve the living conditions of these residents (Flores, 2005, 2006).

Marginalization is described in psychology as a phenomenon with multiple layers. Societies can be marginalized at a global level, while individuals can be marginalized within their local communities. Marginalization is the experience of being barred from social, economic, and political resources that support one’s self-determination (Burton & Kagan, 2005).
Marginalization lies at the heart of exclusion from leading satisfying social lives at individual, interpersonal, and social levels. Exclusion also keeps marginalized people from accessing effective and strong social networks. This can lead to loss of hope and disempowerment. Marginalized populations lack control over the resources available to them and endure limited opportunities in the mainstream. This separation may lead to low self-confidence and sets up a vicious cycle of lack of social support, prevention from participating in mainstream society, leading to further isolation. Social policies perpetuate the marginalization of individuals and populations viewed as existing outside the dominant society. They have limited access to social resources such as education, health care, income, housing, and leisure activities (Burton & Kagan, 2005).

The nursing literature defines marginalization as a sociopolitical process. This process relegates individuals or groups to the periphery, separated from the dominant group or center. Marginalization has been a concept used in nursing to guide research and practice for the past decade (Hall, 1999). Individuals or groups may be marginalized based on their identities, environments, associations, and experiences. The process of marginalization results in limited access to necessary resources and subjects those considered in the periphery of society to differential (lower quality) treatment (Hall, Stevens, & Meleis, 1994).

Marginalization affects the quality of health care received and delivered to marginalized people (Meleis, 1996). This concept is significant in the discussion of health disparities. It is important to understand marginalization as a process, and the responses to, and effects of marginalization on the quality of health delivered to marginalized populations (Meleis, 1996). Nursing needs to continue to develop knowledge about marginalized populations. Research and education should focus on the basic premises of the marginalizing aspects of society, developing
tools to understand the concept, and producing literature that reflects marginalized populations (Meleis & Im, 1999).

Nursing can focus on the social inequalities that exist and from which disparities result. The focus shifts from simply reducing disparity to functions of race, culture, gender or other such variables taken out of its social context. Valuing culture is critical, but in and of itself, will not determine how diverse groups respond to the health care system. Nurses can be careful not to perpetuate cultural stereotypes that support marginalization of ethnic and cultural groups. The extent to which groups experience marginalization determines their response to the health care system. Significant concepts important to nursing include understanding of the process that creates and perpetuates marginalization, the experience of being marginalized, and the consequences of marginalization on the health and well-being of people (Vasas, 2005).

The differentiation from the mainstream or dominant society is a characteristic of marginalization that can result in stigmatization of individuals or groups. Marginalized people are often subject to negative public attitudes, and they become stigmatized (Burton & Kagan, 2005). Stigmatization results from social policies, norms, and cultural standards that label individuals or groups and results in isolation, embarrassment, and humiliation. Stigma can carry a heavy psychological burden and causes increased marginalization of already vulnerable groups (Bayer & Stuber, 2006).

The Chuukese migrants on Guam face the issue of stigma. John Uruo, a traditional chief and former member of the Chuuk legislature, has made Guam his home and discussed the issue of stigma. He works in the Guam courts as a translator for Chuukese who have been arrested. He discussed the problem of stigma, stating that “one of the hardest things about living in Guam is that there is often a stigma attached to being Chuukese because of the high numbers of Chuukese arrests” (Leon Guerrero, 2005, p. 17). Uruo cited this perception stemming from the high
numbers of Chuukese arrested for drunk driving or for domestic abuse. This contributes to a misconception of Chuukese as violent people (Leon Guerrero, 2005).

The fundamental understanding of Chuukese as a marginalized population in Guam—and the consequences of their existence as a vulnerable population—is important to begin any serious discussion of disparities. The process of marginalization creates vulnerable populations who are at higher risk of suffering from health disparities (Meleis, 1996; Vasas, 2005). Conceptualizing the Chuukese migrants as marginalized can assist in broadening the perspective of nurses and other health care and social welfare personnel seeking to make a difference in their health status in Guam. Ignoring their marginalized status and failing to address it will only impede the process of improvement and act to maintain the forces that cause marginalization.

Marginalization results in the “invisibility” of the marginalized. Those in power do not see, or are blind to the marginalized. This phenomenon of “invisibility” may be due to the social and spatial segregation that keeps the marginalized away from the privileged areas frequented by the dominant group. The power and privilege of being in the “center” blind many to the existence and plight of the disadvantaged in the periphery. Those in the mainstream do not understand the marginalized (Vasas, 2005). The literature of the migration to Guam by those from the FSM has documented that many residents in Guam are not aware of the deplorable conditions in which the Chuukese live and have to endure each day (Salvation Army, 2004, 2005). The barriers faced by this population and their perceptions need to be brought to light and shared with the health care community as a step towards eliminating the marginalizing processes that contribute to disparity.

There is scant information in the literature that examines the perceptions of Chuukese about barriers to health care or the factors that may influence their health-seeking behaviors (Aitaoto et al., 2009; Shoultz et al., 2007; Wong & Kawamoto, 2010). More information is
needed to shed light on the complex issue of health disparities. A baseline of information on health and health care disparities in Guam requires additional data collection and research. Advancing knowledge of health disparities in this subpopulation can add to the growing database of minority health information with the goal of improving health care and health outcomes.

**Summary**

The literature on disparities at a national level is extensive and efforts have been ongoing since the end of the 1990s. Numerous studies have documented the existence of disparities experienced by minorities and other priority populations in the United States such as the poor and the elderly (IOM, 2003; U.S. DHHS, 2003). As the goal of reducing disparities became a national priority, efforts began and continued at a national level to gather data and maintain national databases monitoring the state of disparities. For the purposes of this study, the literature of disparities and AAPI populations in the United States were reviewed. Disparities exist in many areas of health for AAPIs (Ghosh, 2003; Louie, 2001). In the area of cancer research, multiple studies found higher rates for AAPI populations for cancers (California Department of Health Services, 2003b; Kwong & Wright, 2003; Kwong et al., 2005, Wu et al., 2006). Among the literature cited on Micronesians, disparities in cancer mortality were significant (Haddock, Talon, & Whippy, 2006). Several studies revealed low to no prenatal care for Micronesians in Guam, and the disparity is significant when compared to national benchmarks for prenatal care and for infant mortality (Guam Bureau of Statistics and Plans, 2005; Haddock et al., 2008). There is a dearth of information in literature reviewed about health disparities among Micronesians, and the literature on Chuukese migrants and disparities is minimal This study aimed to increase the understanding of Chuukese migrants in Guam and begin to shed light on the issue of disparities affecting this population. This research added to the scant body of knowledge existing in the area of health disparities and health-seeking of Chuukese migrants.
Chapter 3

The purpose of this study was to examine perceived barriers to health care among Chuukese migrant women in Guam and to examine what factors may be influencing health-seeking behaviors. Through focus groups and key informant interviews, the researcher aimed to obtain recommendations for interventions that may reduce those perceived barriers to health care. The qualitative approach using focus groups and key informant interviews was selected as most appropriate for this study. The methodology, sample, settings, tools, and plans for data management and analysis used in the study were discussed. The efforts to assure rigor and trustworthiness in this qualitative study were described.

Methodology

Qualitative research allows one to describe and explore the social world and aims to describe a phenomenon about which little is known. The qualitative method explores assumptions and attitudes underlying behaviors within the context in which they occur. The goal is to gain understanding from the perspective of the participants (Morse & Field, 1995). According to Sandelowski (2000), “the qualitative descriptive study is the method of choice when straight descriptions of phenomena are desired” (p. 339). The descriptive qualitative design provides a means to obtain direct answers to relevant questions with the goal of producing a descriptive summary of an event (Sandelowski, 2000).

The descriptive qualitative research approach was chosen as the most appropriate means of exploring the unknown perceptions and beliefs of Chuukese migrant women, from their unique perspective, regarding barriers to health care and the factors that influence their health-seeking behaviors. In order to uncover the perceptions of the Chuukese, from their unique perspective, a descriptive qualitative research approach was deemed most suitable for this study.
The focus group method was appropriate for the research focus and purposes of this study. The use of focus groups for examining sensitive topics has been well documented in the literature (Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007; Morgan, 1997; Speziale & Carpenter, 2007). The popularity of this method in qualitative research is growing, based on its many advantages—inexpensive, stimulating, beneficial in information recall, and capable of eliciting rich data (Speziale & Carpenter, 2007). A purpose of using focus groups is to stimulate self-disclosure; homogeneity in focus groups encourages individuals to share perceptions and decreases perceived risk to participants. Focus groups provide a means of access to attitudes and values of participants while observing interactions among group members (Morse & Field, 1995).

Focus group interviews are appropriate if the intent is to uncover factors that influence behaviors, motivation, or opinions. This method can lead to insights into complex topics when the issues relate to multi-faceted behavior (Krueger & Casey, 2000). Focus groups can provide a voice for those who are socially marginalized and are an effective means of learning about participants’ experiences and perspectives (Halcomb et al., 2007; Morgan, 1997). Focus groups are a useful tool to assist in the understanding of perspectives of culturally and linguistically diverse groups; this information is relevant in shaping clinical practice that more effectively meets the needs of these groups (Halcomb et al., 2007). The focus group method was appropriate to use for the purposes of this study. The purpose of this qualitative descriptive study was to uncover and examine the perceptions of the Chuukese migrant women who participated in the study. The focus group method was appropriate in the efforts to gain new knowledge of their perceptions to the barriers they faced and the factors that influenced their health-seeking behaviors in Guam.
In addition to focus groups, the researcher conducted semi-structured interviews with key informants. The semi-structured interview is useful when the researcher knows most of the questions to ask, but does not anticipate the answers. This method of interview allows the respondent freedom to explain thoughts and situations in their own words. These participant narratives provide the rich descriptive information that makes qualitative research valuable (Morse & Field, 1995). The use of several participants representing different sectors of the groups is important when the participant may be knowledgeable of only part of the social situation (Morse & Field, 1995). Participants for the study are chosen based on their experience with the culture, social process, or phenomenon to be studied (Speziale & Carpenter, 2007).

The researcher selected key informants based on their varied knowledge regarding the health and social needs of the Chuukese migrants in Guam. Key informants included health care providers and community leaders who had experience in working with this population. They informants included a public health nurse, a school health counselor (nurse), social workers from the Guam Memorial Hospital, a nonprofit social services agency, and the Salvation Army Family Services Center, and Chuukese community leaders.

**Pilot Study**

A demographic data sheet, focus group question guide, and key informant interview guide were the instruments for this study. These instruments were tested prior to use in the study. Native Chuukese speakers who were migrants in Guam tested the Focus Group Participant Demographic Data Sheet. A sociologist from the University of Hawaii, specializing in Chuukese culture, reviewed the focus group questions and key informant questions for appropriateness and clarity. The focus group questions and demographic questionnaire were available in both English and Chuukese. The instruments required pilot testing to assess the amount of time needed to
complete the questionnaire, determine if instructions were clear, and identify if participants find anything that is inappropriate about the questions (Wilson, 1985). The researcher conducted focus groups with Chuukese women as a pilot study to test and refine the instruments.

A professional translation service from the Micronesian Language Institute translated the descriptive statistics questionnaire, consent form, and the focus group questions. The Micronesian Language Institute offers translation and interpretation services and conducts research in the area of indigenous Micronesian languages. Established at the University of Guam in 1990, the Institute is a regional leader in the area of Micronesian languages (Micronesian Language Institute, 2006). According to the *Oxford English Dictionary* (2012), the word translate is defined as “to turn from one language into another language retaining the sense.”

The researcher, who moderated the focus groups, used a female Chuukese translator to restate the researcher’s words from English into Chuukese during recruitment and focus group sessions.

**Focus Group Questions**

After reviewing the literature on focus groups, and particularly focus groups with minorities and AAPI groups (Strickland & Strickland, 1996; Williams & Hampton, 2005), and the methods of Krueger and Casey (2000), the researcher developed 11 focus group questions. Krueger (1998) recommended five types of questions: opening, introductory, transition, key, and ending. The opening question was designed to enable participants to feel connected and become familiar with one another. The introductory question began the discussion of the topic and could be answered quickly. The transition questions moved the discussion into the key questions that drove the study. The key questions required adequate time to obtain sufficient information. The ending question ended the session and allowed members to reflect on the previous comments (Krueger, 1998).
The following were the focus group questions:

1. Please tell us your name and how long you have lived in Guam. (Opening)

2. What do you think is “good health care”? (Introduction)

3. Can you describe when you would seek health care services? (Transition)

4. What are the main health problems affecting your health and your family’s health? (Key)

5. What are the main barriers that you encounter when trying to obtain health care for yourself and your family? (Key)

6. What are your experiences with health care in Guam? (Key)

7. Have you ever felt that a health care worker treated you badly? Please describe your experience and how you felt. (Key)

8. When would you or your family prefer to use traditional Chuukese medicines? (Key)

9. If you could suggest anything to improve health care for Chuukese in Guam, what would that be? (Key)

10. Is there anything else about this topic that you think I should know? (Ending)

11. Do you have any concerns that have not been addressed today? (Ending)

**Interview Questions for Key Informants**

This list of questions were in English and did not require translation, because the key informants were English speaking. The following were the questions for the key informants:

1. What types of health problems do Chuukese migrants have most often?

2. What kinds of problems do Chuukese migrants have in getting good health care?

3. What kinds of problems do Chuukese migrants have in maintaining good health?
4. Where do you think Chuukese migrants are most likely to go when they need health care?

5. Have you observed Chuukese migrants in Guam being marginalized or stigmatized?

6. If you could suggest anything to improve health care for Chuukese in Guam, what would that be?

7. Is there anything else about this topic that you think I should know?

8. Do you have any concerns that have not been addressed today?

**Sample and Setting**

When choosing the focus group method, the sample should consist of participants who have a shared experience on which the discussion can focus and build. Purposeful sampling is appropriate to understand the topic of study. Researchers select individuals who have firsthand experience with the phenomenon of interest (Speziale & Carpenter, 2007). In a descriptive qualitative study, purposeful sampling is appropriate to obtain information-rich cases (Sandelowski, 2000).

Based on the cultural norms for behavior in Chuukese society, in particular, the incest taboo described previously, it was determined that the sample for the focus groups, would consist of Chuukese women only. Krueger and Casey (2000) also validate the rationale for not combining genders; they identified mixing genders in a focus group as unwise in some circumstances. They refer to the “peacock effect” in which male participants speak more often than females and exert authority in the group (p. 73).

The focus group sample included Chuukese migrant women, 21 years of age or older. English speaking ability was not a limitation of the study since a translator was available during focus group sessions. The women were migrants who had lived in Guam for at least one year.
Migrants who had not been in Guam for at least one year were ineligible because they may not have had exposure adequate to provide information needed about the topic. The women were willing to participate in focus groups. Focus groups were held in various Chuukese neighborhoods around the island. According to Morse and Field (1995), homogeneity in focus groups encourages individuals to share perceptions and decreases perceived risk to participants.

Key informants included health care providers and community leaders who had worked closely with the Chuukese population. The key informants were selected based on their varied knowledge regarding the health and social needs of the Chuukese migrants in Guam. The participants included a public health nurse, a school health counselor (nurse), social workers from the Guam Memorial Hospital, the Guam Department of Public Health and a nonprofit social services agency, and the Salvation Army Family Services Center, and Chuukese community leaders.

The setting for the focus groups would be comfortable, socially acceptable, and non-threatening to the group members (Winslow, Honein, & Elzubeir, 2002). Convenience and comfort for the participants are primary considerations in choosing the location for focus groups (Morgan, 1998). Winslow et al. (2002) suggested that the researcher consider settings in which the participants normally congregate. The settings for the study were the various neighborhoods in which the Chuukese women in the sample reside. The focus groups were held in neighborhood locations such as group meeting areas, church social halls, village mayors’ offices, or participants’ residences. The researcher was aware that the cultural norm in one particular Chuukese community was to seek verbal permission from the Chuukese chief to hold a focus group in his neighborhood. The consent of the Chief was key to reaching the Chuukese women in this community and in their willingness to participate in the focus group. This permission was
granted prior to recruitment within the specific neighborhood. The Chuukese participants in other villages did not live in similar Chuukese enclaves. Interviews with key informants were conducted at their work setting or other location chosen by the key informant. The setting for key informant interviews was consistent with the recommendation that it be one that was comfortable and enabled them to speak openly about the topic (Winslow et al., 2002).

**Instruments**

After pilot testing for refinement of instruments, the final instruments included:

1. **Focus Group Participant Demographic Data Sheet.** This is a demographic questionnaire. Data included the year the person was born, years lived in Guam, years of education, number of biological children, primary language spoken in the home, insurance status, income (range), island of origin, and usual source of health care. This was a one-page checklist. Krueger (1998) recommended a single page form that is easy to complete and will not take time away from the focus group session. (See Appendix C).

2. **Focus Group Questions.** (See Appendix E).

3. **Interview Guide: Key Informant Interviews.** (See Appendix G).

**Data Collection Procedures**

**Completion of demographic data sheet.**

In the process of conducting the study of Marshallese Immigrants in Arkansas by Williams and Hampton (2005), researchers utilized bilingual Marshallese moderators to facilitate completion of a questionnaire. The moderators read the questions aloud to the group as the questionnaire was completed (Williams & Hampton, 2005). Rather than registering participants individually, a similar strategy was implemented for completion of the descriptive statistics
questionnaire in this study. Prior to the start of each focus group, the researcher was assisted by a Chuukese female translator with experience in translating for Chuukese clients accessing and using health care services in Guam. The researcher assisted participants as needed in completing the questionnaire while the translator read each question to the group in Chuukese. Focus groups began after the participants completed the questionnaire.

**Focus groups**

Focus groups were conducted following the method described by Krueger and Casey (2000), and Morgan and Krueger (1998). A single category design, a traditional design in which the researcher has one feature of interest, was used. The researcher does not need to compare and contrast based on other characteristics or features (Krueger & Casey, 2000). The purpose of this study was to examine barriers to health care among Chuukese migrant women in Guam and to examine what factors influenced health-seeking behaviors. The intent of the study was not to compare and contrast responses from various ethnic groups, or genders, or other such categories. Therefore, a single category design was appropriate. The focus groups consisted of Chuukese migrant women in Guam. Groups were conducted until saturation was reached. The traditional design of focus groups is to conduct groups until the researcher attains theoretical saturation; the point at the researcher gains no new information (Krueger & Casey, 2000).

Traditional focus groups are comprised of six to eight participants (Krueger & Casey, 2000). For this study, the size of the focus groups was limited to five women. Krueger and Casey (2000) refered to groups of this size as mini-focus groups, with four to six participants. These small or mini groups are gaining in popularity because of the ease of recruitment and hosting small numbers, and they are comfortable for the participants. A disadvantage of small groups is the total range of experiences may be limited because the group is smaller (Krueger & Casey,
There are appropriate uses, however, for the smaller group size, for example, when the participants are highly involved in the topic and have much knowledge of the topic (Morgan, 1998). For the purposes of this study, the use of small groups with five members was appropriate.

Additional considerations for using smaller groups are when the topic is complex and when the purpose is to obtain detailed stories and personal accounts. Smaller group sizes may allow participants increased opportunity to express themselves and researchers to hear more from each participant about the topic (Krueger & Casey, 2000; Morgan, 1998). Small groups are a significant advantage when it is important to learn about each participant’s thoughts, feelings, and experiences (Morgan, 1998). In the literature reviewed on focus groups conducted by the Salvation Army with Chuukese women and teens in Guam (2004), the groups were comprised of 4 to 5 members and were successful in obtaining rich information from the participants.

The researcher conducted focus group interviews until saturation was reached. Saturation is achieved when the data are repeating and no new themes are arising from the data collection (Speziale & Carpenter, 2007). After completion of focus group interviews, the researcher conducted key informant interviews, then returned to the focus group participants for member checking and verification of findings. Member checking for verification of descriptions and themes is important in supporting the rigor and credibility of the study (Speziale & Carpenter, 2007).

**Interviews with key informants**

After conducting the focus groups, the researcher conducted semi-structured interviews with key informants. The semi-structured interview is useful when the researcher knows most of the questions to ask, but does not anticipate the answers. This method of interview allows the
respondents freedom to explain thoughts and situations in their own words. These participant narratives provide the rich descriptive information that makes qualitative research valuable (Morse & Field, 1995).

The interviews with key informants were conducted at their work sites or other private setting convenient for the interviewee and where the interviewee felt comfortable to speak freely. The interviews were conducted in English and audio taped and digitally recorded. Field notes were used to document prominent themes and nonverbal behaviors not captured by audiotape (Côté-Arsenault & Morrison-Beedy, 1999). Another use of field notes is to record personal insights (Speziale & Carpenter, 2007). Key informants were interviewed for up to 2 hours in one interview session. The researcher conducted member checking with the key informants in order to verify the identification of themes with participants to ensure rigor and credibility of the study (Speziale & Carpenter, 2007). In the planning process, it was anticipated that a second key informant interview might be needed to clarify data and validate findings. This second interview would be conducted via telephone or in person and would last no more than 30 minutes. The second interview was to be conducted to validate the accuracy of the transcripts and validate the researcher’s accounts of interviews and findings. The researcher selected key informants based on their ability to provide relevant information about Chuukese migrants and issues surrounding their health and health care in Guam.

**Data Management**

The researcher used the software program SPSS 15.0 to manage the demographic data from the Focus Group Participant Demographic Data Sheet. Data included in the demographic questionnaire were the year person was born, years lived in Guam, years of education, number of
biological children, primary language spoken in the home, income (range), insurance status, island of origin, and usual source of health care (See Appendix C).

The researcher transcribed the key informant interviews verbatim. The Micronesian Language Institute at the University of Guam would perform the transcription, translation, and back translation of the focus groups as the groups were conducted in Chuukese. The researcher managed the qualitative data manually and with the use of the ATLAS.ti 5.2 qualitative data management program.

**Analysis of Data**

According to Krueger and Casey (2000), focus group data analysis is “systematic, sequential, verifiable, and continuous” (p. 128). Focus group analysis occurs concurrently with data collection processes. An audit trail is vital to the analysis process. Systematic, sequential procedures ensure that results reflect what occurred in the groups and helps in avoiding mistakes or overlooking key factors. A strategy for analysis of data is planned, documented, and evolving (Krueger & Casey, 2000). The clear, documented audit trail will lend to the confirmability of the findings (Speziale & Carpenter, 2007).

There must be sufficient data for results to be verifiable. These data included field notes, audio taped recordings of interviews and focus group sessions, transcripts, debriefing and verification of key points with group members (Krueger & Casey, 2000). Procedures recommended by Côté-Arsenault & Morrison-Beedy (1999), and Speziale & Carpenter (2007) were followed. A female nursing student and a recent nursing graduate were present as note takers during all focus group sessions. Notes included the seating arrangement during the focus group sessions, the order in which the participants spoke to aid in voice recognition, and nonverbal behaviors such as gestures, eye contact, or fidgeting (Côté-Arsenault & Morrison-
The researcher also took field notes during the key informant interviews. Field notes can be a valuable tool during transcript preparation. Detailed notes can assist in interpretation of the audiotaped sessions by indicating information, such as nonverbal behaviors, that the audiotape does not capture (Côté-Arsenault & Morrison-Beedy, 1999). Field notes can describe assumptions about what the researcher hears during interviews and can include a personal narrative about what the researcher experiences while conducting the study (Speziale & Carpenter, 2007).

Sandelowski (2000) asserted that when conducting qualitative descriptive studies, the method of choice for data analysis is qualitative content analysis. The researcher generates codes from the data, and analysis is a reflexive process. Data collection and analysis occur simultaneously and both steps affect each other (Sandelowski, 2000).

Morse and Field (1995) described content analysis as “analysis by topic, and each interview is segmented by these topics into categories” (p. 140). The researcher reads each interview and identifies significant topics. The topics become the primary category labels and are broad to begin with as a means to sort large amounts of data into manageable groups. The researcher can combine categories when sufficient data are generated and then sort them into subcategories (Morse & Field, 1995). When theoretical saturation is reached, the researcher will write descriptive paragraphs about each category and look for relationships between the categories. The researcher can identify if relationships between categories may be antecedents, concurrence, or consequences of a primary category (Morse & Field, 1995).

The goal of qualitative data analysis is to shed light on the experiences of those who have lived the phenomenon of interest (Speziale & Carpenter, 2007). The aim of this study was to
uncover and share the perceptions of barriers to health care services and the factors that influenced the health-seeking behaviors of Chuukese migrant women in Guam.

**Efforts to Assure Trustworthiness**

Prior to conducting the study, the researcher took steps to explicate her beliefs, thoughts, personal biases, and suppositions regarding the topic of study. The researcher used the process of bracketing. The cognitive process of bracketing is a means of setting aside one’s beliefs regarding the topic of interest, and not making judgments about what is and heard (Speziale & Carpenter, 2007). Through the act of bracketing, the researcher makes clear her beliefs and sets them aside, thus remaining open to data as they are discovered (Speziale & Carpenter, 2007).

In efforts to ensure rigor, the researcher wrote down feelings, thoughts, and presumptions prior to the start of the study and continued throughout the course of the study through journaling. Speziale and Carpenter write that “Journaling during the time that one is engaged in the research also helps to keep an open mind and differentiate what the researcher’s thoughts are versus the ideas, comments, and activities of the participants” (2007, p. 27). Lincoln and Guba (1985) referred to reflexive journaling as one of several techniques the researcher can use to safeguard against investigator bias. Reflexive journals are an introspective account of the researcher’s philosophical perspective, cognitive processes, and bases of decision-making during the study (Lincoln & Guba, 1985).

Speziale and Carpenter (2007) described the importance of rigor in qualitative studies: “The goal of rigor in qualitative research is to accurately represent study participants’ experiences” (p.49). Lincoln and Guba (1985) proposed four operational techniques to address trustworthiness in qualitative research: credibility, transferability, dependability, and
confirmability. The researcher used a variety of techniques to establish that each criterion was met and to assure trustworthiness of this study.

Credibility

Methods employed in this study to increase the likelihood that findings will be credible included member checking, persistent observation, and peer debriefing. Member checking for verification of descriptions and themes are essential for credibility of the study (Speziale & Carpenter, 2007). The researcher returned to study participants to verify findings and interpretations of the data. Persistent observation is a means of identifying the most relevant elements of the situation being studied and focusing on them in detail. The researcher provides an in-depth explanation of how the most relevant factors are identified and how the detailed examination took place (Lincoln & Guba, 1985). Another means of achieving credibility is through peer debriefing. Peer debriefing is a process through which the biases of the researcher are assessed, interpretations of the data are explicated, and meanings are investigated (Lincoln & Guba, 1985). The researcher used peer debriefing throughout the course of the study in efforts to assure credibility.

Transferability

Speziale and Carpenter (2007) defined transferability as the likelihood that “findings have meaning to others in similar situations” (p. 49). Efforts by the researcher to provide rich, detailed descriptions of culture and context, participant characteristics, data gathering, and analysis of data along with meaningful quotations from participants facilitate transferability of findings (Granheim & Lundman, 2004). In the process of reporting the findings of this study, the researcher provided thick, rich, exhaustive descriptions of the findings with appropriate quotations from participants as a means for others to determine whether study findings are
transferable in other situations (Lincoln & Guba, 1985). Lincoln and Guba (1985) asserted that it is not the duty of the researcher to determine the “index of transferability; it is his or her responsibility to provide the data base that makes transferability judgments possible on the part of potential appliers” (p. 316). The researcher followed the recommendations of Lincoln and Guba (1985) by providing thick, rich data that may enable others to make determinations regarding transferability.

**Dependability**

Methods to achieve study credibility also assisted in determining dependability (Lincoln & Guba, 1985). An inquiry audit of the study by an external reviewer, however, is another direct means of demonstrating dependability. Lincoln and Guba (1985) used the analogy of a fiscal audit by an external reviewer to describe the inquiry audit in a qualitative study. The fiscal auditor reviews the documentation for accuracy and provides a determination of the dependability of the account ledgers (Lincoln & Guba, 1985). In conducting this study, the researcher maintained a clear audit trail, with an external review by a sociologist regarded for her knowledge of, and work with, the Chuukese in Guam and Hawaii. The external reviewer examined the process, findings, and interpretations to establish dependability and confirmability at the same time (Lincoln & Guba, 1985). The external review and audit trail were used to achieve dependability in this study. The audit trail is also a means to achieving confirmability (Lincoln & Guba, 1985).

**Confirmability**

The audit trail and the process of conducting the audit are major techniques for establishing confirmability (Lincoln & Guba, 1985). A detailed audit trail is the recording of activities conducted during the course of the study that can be followed by another individual
(Speziale & Carpenter, 2007). Sandelowsi (1986) described the audit trail as “a clear decision trail concerning the study from its beginning to its end. Very simply, auditability means that any reader or another researcher can follow the progression of events in the study and understand their logic” (p. 34). To establish confirmability of this study, the researcher maintained a detailed audit trail including such information as the raw data, the process of data collection, and methods of analysis. The researcher also documented how interpretations were reached. Additional information for the audit process includes detailed field notes, the reflexive journal, written transcripts, and the external review (Lincoln & Guba, 1985). The researcher maintained and updated a research journal that included the process of decision making that occurred during data analysis.

Translation and back translation of focus group sessions were completed to assure credibility and reliability of the data. All interviews and focus group sessions were audio taped and digitally recorded, then transcribed. Transcription of focus group sessions necessitated translation into English. The Micronesian Language Institute based at the University of Guam provided professional translation services for translation of all forms used during the study. The Institute is known for its research and translation services for indigenous Pacific Island languages and cultures (Micronesian Language Institute, 2006).

The Micronesian Language Institute translator was not available to translate the focus group transcripts, so this was done by a translator from the Guam Department of Public Health and Social Services who was considered reputable by the research community in Guam. A translator with experience working in the Guam legal and mental health care systems performed the back-translation. The back-translator also had prior experience in the Chuukese Public Health Department before relocating to Guam. The researcher prepared verbatim transcripts of the key
informant interviews and entered the transcripts into the Atlas.ti program. The researcher maintained a methodological log detailing the analysis and decision-making process. The researcher performed these procedures as a means to demonstrate rigor and assure trustworthiness of this study.

**Protection of Human Subjects**

Approval from the Institutional Review Board (IRB) of Villanova University was obtained. The University of Guam IRB also provided approval of the study because the study was conducted in Guam. After receiving IRB approval from both institutions, the research study was conducted. During initial participant contact, the researcher explained the purpose of the study, benefits and risks, audio taping of interviews, the voluntary nature of the study, ability of the participant to withdraw at any time or to refuse to answer any questions, steps taken to assure participant confidentiality, and the time commitment of the participant. The researcher provided the women with a $25.00 gift card to a local grocery store for their participation in the study. This information about the incentive for participation was included during study recruitment using the Script to Solicit Focus Group Participants (See Appendix K). The use of the incentive was described in the Villanova and University of Guam IRB approvals. The researcher informed the participant of the consenting process before each interview. The researcher provided these explanations in English with a Chuukese translator present to explain in Chuukese for each of the focus group sessions.

The researcher implemented process informed consent (also called consensual decision-making) procedures. The qualitative method requires that, at varying instances in the research process, ongoing consent and re-evaluation of the participant’s consent is performed (Speziale & Carpenter, 2007). Participant were reminded at the beginning and throughout the study of their
right to withdraw at any time. Process informed consent is appropriate when conducting a qualitative research study (Speziale & Carpenter, 2007). A female Chuukese translator was present at all focus groups and at all consenting procedures for the focus group participants. The translator was a Chuukese female with experience in translating for Chuukese clients accessing and using health care services in Guam. It was important to have a female translator during the focus groups, due to cultural gender restrictions.

The consent was available in English and Chuukese for focus group participants (See Appendices H and I). Translation services were not required during the consent procedures or the interviews with the key informants; the key informants were fluent in English (See Appendix J). The researcher informed all participants verbally and in writing about the use of the results. There was adequate time allotted for participant questions and to ascertain if the participant understood what was proposed. The researcher provided all participants with a copy of the consent form (available in Chuukese and English for focus group participants and in English for key informants). Before conducting any subsequent interviews (as needed for data clarification and validation), the researcher repeated the consenting process.

Researchers must also protect the psychological and physical welfare of their participants, supporting the principle of beneficence (Speziale & Carpenter, 2007). Discussions may elicit emotions that cause distress to the participants. The researcher had planned to refer participants to social workers or counseling services if needed. The Guam Department of Public Health and Social Services and the Salvation Army have social workers and counselors who would be available for referrals at no cost to study participants. Although anxiety was identified as a slight risk for participating in the study, no participants displayed anxiety or became upset during or immediately following the focus group sessions. The researcher-participant
relationship can cause ethical concerns, and care must be taken to avoid confusion of the researcher role and differentiate the role of researcher from that of counselor, friend, or therapist (Speziale & Carpenter, 2007).

The researcher maintained and protected the confidentiality and anonymity of participants. In using thick, rich descriptions given by participants in qualitative studies, researchers must make every effort to protect confidentiality (Speziale & Carpenter, 2007). When the study was completed, the researcher erased all original audio tapes and digital recording media of interview data. All transcripts and computer data were deidentified using a code number only. The Focus Group Participant Demographic Data Sheet had deidentified data with an assigned code number. All field notes contained deidentified information only.

The researcher kept all study materials secure under lock and key. The final study report did not include any identifying information about the participants, and although some of the information they provided may be published, their names and any identifying data will not be associated with any publication. Transcripts and computer files were kept under lock and key at the researcher’s home office for the duration of the study and will be maintained securely for 7 years after study completion. The researcher will destroy all study data after 7 years.

This descriptive qualitative research study was designed to examine barriers to health care among Chuukese migrant women in Guam. Additionally, the study provided knowledge about the factors influencing the health-seeking behaviors of this population and elicited recommendations for interventions to decrease barriers to health-seeking. The information added to the current knowledge of the factors that influence health-seeking behaviors and about barriers to care among the Chuukese people in Guam. The knowledge gained through this research can
assist nurses, other health care providers, and policy makers in the planning and implementation of strategies to improve health care and health outcomes for this growing population in Guam.

**Summary**

This research study used a qualitative descriptive design. The use of focus groups elicited data on perceptions of Chuukese migrant women and provided the opportunity for participants to make recommendations to decrease these barriers. The focus group method was appropriate as a means to gain new knowledge of the perceptions to the barriers faced by Chuukese migrant women in Guam and the factors that influenced their health-seeking behaviors. Focus groups were conducted until data saturation was achieved. The researcher also conducted semi-structured interviews with key informants selected for their varied knowledge regarding the health and social needs of the study population. The researcher conducted qualitative content analysis using the reflexive process of data collection and analysis. Protection of study participants was addressed as well as the procedures for maintaining confidentiality. The researcher diligently employed efforts to ensure trustworthiness of the study. The decision-making process was recorded in the research journal during data analysis. The dependability of the data analysis was achieved through examination by an external reviewer with expert knowledge of Chuukese women. The information gained from this study can assist in the efforts to improve the complex problem of disparities as it affects this population in Guam.
Chapter 4

The purpose of this study was to examine perceived barriers to health care among Chuukese migrant women in Guam and to examine what factors influenced health-seeking behaviors. Through focus groups and key informant interviews, the researcher’s goal was to obtain recommendations for interventions that may reduce those perceived barriers to health care. The research study used a qualitative descriptive design. In this chapter, the researcher presents the findings of the study, study methods, data analysis, description of the participants, and the themes that emerged from the data. Statements from the participants provided rich descriptions of the significant findings and validated the identified themes.

**Study Method**

Prior to conducting the focus groups, the forms and questions were pilot tested with five participants. The pilot participants were bilingual English/Chuukese speaking women. Three of the participants were University of Guam students, while the other two participants were women who had lived in Guam since 1993 and 1994, respectively. All participants were fluent in English and Chuukese. The pilot testing provided an opportunity for the translator and note takers to practice the data collection method prior to conducting the actual study. Pilot group participants stated that the questions were accurately translated. Several women felt the Chuukese translation of the word “island” on the demographic data sheet might also mean “region.” The Chuukese word has more than one interpretation. The women suggested that the researcher and translator be aware that some women may misinterpret the word on the Focus Group Participant Demographic Data Sheet (See Appendix D). Some Chuukese would better understand the word “island” and be able to give a more specific response as Chuuk is comprised of close to 290 islands (Pacific Resources for Education and Learning, 2005b). This advice was
heeded when the translator assisted participants in completing the demographic data form prior to beginning each focus group. The translator instructed the women to provide the name of the island, rather than the specific region they were from originally.

**Pilot study**

The pilot study was conducted to test the methodology and to help the translator and notetakers become familiar with the data translation. The findings from the pilot study were that the inability to understand English, lack of health care insurance, and transportation difficulties were barriers to seeking health care for the Chuukese migrant women in Guam. Participants also reported they did not use Chuukese medicines but had family members in Chuuk who used various herbs, oil, tea, and massage to treat illnesses. Data from the practice groups were used to inform the researcher and help refine the methodology, but were not included in the final data analysis.

**Focus groups**

The study began with focus group recruitments. The researcher recruited focus group participants with translator assistance using the Script to Solicit Focus Group Participants (See Appendix K). Meeting times and location for the group were set up during the initial contact. Focus groups were then conducted. The first group was held in an outdoor common meeting area in the women’s neighborhood. The other four groups were conducted in private homes familiar to the participants. At least one participant in each group lived in the home where the focus group was held. The participants within each group were known to each other as either close friends or family members.

There were five focus groups conducted with a total of 22 participants. One participant in the first group did not meet the selection criterion, however, and was eliminated from the data
analysis, leaving a sample size of 21 women. The participant was a Chamorro woman related to one of the Chuukese women in the group. Chamorros are the indigenous peoples of Guam and are the predominant ethnic group in the island. Because of the personal nature of the setting and the relationship of the participant to others in the group, the researcher determined it was culturally appropriate to allow the woman to stay in the focus group. Refusing to allow her to participate may have offended her and other participants. Prior to beginning the focus group, the researcher instructed the note takers to be attentive to the possible effect of her presence on the group members. The facilitator paid close attention to the possible influence her participation may have had on the rest of the group members.

The researcher determined that the Chamorro female participant did not appear to influence the responses of the Chuukese women. After review of the transcripts and field notes, including discussion with the note takers and female translator who were present, it was determined that her statements did not appear to influence the responses of the other women. She has been a long-time member of the community in which the focus group was held. Her comments were not included in the data analysis. She was not included during the member-checking for verification of themes, but did receive the incentive gift certificate for her time. This situation occurred in the first group and greater care was taken during recruitment to ensure this did not occur in subsequent focus groups. The Chuukese translator accompanied the researcher during focus group recruitment and reviewed the inclusion criteria with the potential participants using the Script to Solicit Focus Group Participants (See Appendix K).

Consenting procedures were conducted with the assistance of the translator before conducting the focus groups. The translator read the Chuukese language consent form aloud before the women signed it. Participants were given the opportunity to ask the researcher
questions, with the researcher providing explanations in order to obtain informed consent. After consent was obtained from each participant, the demographic questionnaire was completed. The translator assisted by reading each question of the demographic questionnaire aloud as the women completed the form. Participants received a copy of the consent form prior to beginning the focus group session.

Focus groups were conducted and the groups recorded digitally and with an audiocassette tape recorder. All digital recordings were successful and the researcher downloaded the recordings onto the researcher’s password protected laptop, deleting the session from the digital recorder within one day of completing the focus group. The cassette tapes are kept in a locked file cabinet accessible only to the researcher. The researcher took field notes during each group session. Trained note takers who were senior nursing students when the study began took additional field notes. They continued as note takers after they graduated from their university. The researcher trained the two note takers who were both present during the pilot groups and the first focus group session. One of the trained note takers was present for each of the subsequent focus groups. The researcher conducted a debriefing at the conclusion of each group session with the note taker and translator to ensure accuracy of the data. The researcher conducted debriefings after each group and any additional relevant information written in a research journal.

The researcher conducted focus groups until the data were repeating and no new themes were emerging (Speziale & Carpenter, 2007). This occurred during the fifth focus group. No new themes emerged and it was determined that saturation was reached. The researcher reviewed the transcripts to ensure saturation was reached before the key informant interviews were conducted. The external reviewer, a sociologist from the University of Hawaii Center for Pacific Island
Studies, and the researcher’s dissertation chairperson, were consulted to assist in the
determination of saturation.

After each focus group was completed, the researcher transcribed the English speaking
portions of the group session. The transcripts and the digital recordings of each group were given
to a translator from the Department of Public Health and Social Services. He then translated
verbatim the Chuukese portions of each group. The translator from the Micronesian Language
Institute who had originally translated all the forms and questions into Chuukese was
unavailable. The translator from the Department of Public Health and Social Services had
translated Guam Public Health documents into Chuukese and was considered a reputable
translator by the research community in Guam. After receiving each translated transcript, the
researcher inserted the translations into each group’s transcript.

The researcher coded the transcripts initially by identifying significant statements.
Analysis of the statements was performed to determine broad meanings. Coding and analysis
occurred as a reflexive process (Sandelowski, 2000). Through content analysis, themes were
constructed based on the focus group data. The data analysis process will be described in further
detail in this chapter. Back-translation was completed, with the exact content of each focus group
back translated from English into Chuukese for the purpose of assuring credibility and reliability
of the data. The researcher met with the back-translator to review the interpretation of the
women’s statements and the major themes identified by the researcher before reviewing the final
transcript with the women for verification. The back-translator had experience working as a
translator within the Guam legal and mental health care systems. He also had prior experience in
the Chuukese Public Health Department before relocating to Guam.
After completion of focus group interviews, the researcher began to conduct key informant interviews. The researcher transcribed key informant interviews, identified significant statements, and continued the coding process. The transcripts, initial coding, and themes identified from the focus group data were reviewed prior to returning to the women for verification. Validation of findings was conducted after all key informant interviews were completed and the data were continually analyzed. Using process informed consent, the researcher again reviewed the consent with the women before verifying the findings. When conducting qualitative research studies, process informed consent is an appropriate means of re-evaluating participants’ consent (Speziale & Carpenter, 2007). The right of the participant to withdraw from the study was reviewed at the start of the second validation meeting with the women. The women received the incentive gift certificate to a local grocery store after member checking for verification of themes was completed.

**Description of Participants**

All 21 participants reported speaking Chuukese most often in their home. The educational background of the participants was reported as 28.57% (n=6) completed grade school, 57.14% (n=12) completed high school, and three of the women had completed the 11th grade. All participants reported total household income less than $10,000/year. The average family size was 6.67 people in a family with an average of 4.3 children. The local public health care center in one region of the island was identified by 9 of the 21 women as their usual source for obtaining health care. Another public health care center in a different region of the island was identified as the usual source of health care for 6 of the 21 women. The public health care center in a third area of the island was the usual source of health care for one participant. The usual source of health care for 2 of the 21 women was the local civilian hospital or the local military
hospital. Three of the women reported using either the civilian hospital or one of the public health care centers as their usual source of health care. The participants lived in Guam an average of 10.14 years, ranging from the person who lived the longest time in Guam of 22 years, and the person who lived the shortest length of time in Guam of 3 years.

After the participants revealed no new information, the researcher interviewed the seven key informants. The key informants had knowledge of Chuukese migrant women and experience working in various Guam health and social services agencies. Two key informants were registered nurses. Three key informants were Chuukese: one worked in an educational setting, one worked in a health care agency, and the third worked in a social services agency. The other two key informants were social services workers: one case worker in a social services agency and one social worker from a health care facility. All key informants had extensive experience working with Chuukese migrant women in Guam.

Analysis of the Data

The researcher reviewed all transcripts from focus group and key informant interviews. Field notes were also reviewed after each focus group and key informant interview was completed. The field notes were used to provide further descriptions, personal thoughts and feelings during the data collection, and decisions made during data analysis. Another purpose of field notes was to enable the researcher to place the interview or group session within context and to indicate changes to the data collection process (Morse & Field, 1995).

The researcher listened to the digital recording of each focus group at least three times and the key informant interviews twice before beginning the coding process. Each focus group transcript was reviewed multiple times both before and after the English translations were completed. The transcripts were entered in Atlas.ti for data management and analysis. The
researcher identified significant statements and extracted them from the transcripts. The statements were analyzed to determine broad meanings. The researcher used content analysis during this study (Morse & Field, 1995).

After reviewing significant statements, codes were created based on the content or topic identified from the transcripts. The codes were generated from the data, with data collection and analysis occurring as a reflexive process (Sandelowski, 2000). After creating codes, repeating codes were identified and sorted into categories. These categories were determined based on codes that shared a commonality. The categories were broad and used as a means to sort large amounts of data into manageable groups (Morse & Field, 1995).

As the researcher analyzed the data, one finding was identified that needed further discussion and clarification with the focus group participants. Confidentiality concerns emerged as a topic that needed investigation with the women and was identified prior to returning for verification. Women in the third and fourth focus groups had raised the subject of confidentiality; however, confidentiality was not identified in the subsequent groups as a barrier to seeking health care. The researcher then returned to the original focus groups to verify findings and further explore the topic of confidentiality with the women. Verifying descriptions and themes with participants through member checking is important to support the rigor and credibility of the study (Speziale & Carpenter, 2007). The researcher described the category of confidentiality concerns further in this chapter.

During the data translation and back translation of the fifth group, the researcher recognized the importance of member checking and the delicate nature of working with a non-English speaking population. During the fifth group, the women were laughing hysterically as one woman gave an account of her experience at the local hospital emergency room. The
researcher did not know why the women were laughing, and the women would not offer an explanation when asked to provide one. The researcher mistakenly interpreted that they were laughing because a participant went to the hospital with complaints of chest pain and was sent away with a prescription for Tylenol. The researcher thought perhaps they felt it was absurd and funny, hence the laughter. It was confusing, however, because the women were smiling. Field notes documented the nonverbal behaviors and provided data to assist in the interpretation of the situation. Their nonverbal behavior did not seem to indicate they were upset or angry as the woman described her experience.

The researcher reviewed the recorded interview with the translator and the back translator for assistance in interpreting the situation. The back translator stated he was unsure, but perhaps the laughter was due to the woman being treated as if she was naïve. The back translator verbalized his interpretation stating, “Maybe she thought: ‘give her Tylenol and she’ll go away’, I don’t know for sure.” Upon verification of findings, one woman stated they were laughing because “She never goes to the hospital. She always prays instead.” The other women nodded their heads in agreement. Their laughter was at the woman for her usual practice of praying rather than seeking medical care when needed. Another woman stated they were teasing her because “she never goes to the hospital or doctor even if she is sick.” This example validated the importance of member checking for verification of themes and provided an explanation for the group’s nonverbal behavior noted by the researcher and note taker.

Further analysis resulted in the identification of subcategories within the broader category. The researcher developed themes, or expressions, of the latent meanings derived from the data (Graneheim & Lundman, 2004). Analysis of the data occurred with the researcher constructing the following themes: barriers to seeking and maintaining health; social and cultural
factors influence health-seeking behaviors; and political influences affecting migrants. A discussion of these themes and the identified categories and subcategories is contained in the following sections. There were sufficient data for analysis, which included field notes, transcripts, debriefing notes, and verification of findings with participants.

The external reviewer, a sociologist regarded for her knowledge of and work with the Chuukese in Guam and Hawaii, was consulted to scrutinize the findings and the researcher’s interpretations. The external reviewer examined the researcher’s identification of themes and interpretations of the data prior to returning to participants for verification. The external reviewer concurred with the decisions of the researcher. An audit trail was kept detailing the analysis and decision-making process. The researcher conducted these steps as a means to demonstrate rigor and assure trustworthiness of this study. The external reviewer and audit trail were important in establishing dependability and confirmability in qualitative research as described by Lincoln and Guba (1985). An audit trail was maintained using the Atlas.ti program and by journaling in a word processing program. The codes, subcategories, categories, and themes constructed form the content analysis are presented in Appendix O.

**Themes Identified From the Data**

The purpose of this study was to examine perceived barriers to health care among Chuukese migrant women in Guam and to examine what factors may be influencing health-seeking behaviors. The researcher organized the themes identified based on the study purpose with descriptions of the categories and subcategories identified for each theme. The researcher compiled the recommendations for interventions to decrease barriers to health-seeking elicited from the participants. Descriptions from the participants and key informants validated the themes, categories and subcategories identified from the data.
The themes that emerged were: Barriers to Seeking and Maintaining Health; Social and Cultural Factors Influence Health-seeking Behaviors; and Political Influences Affecting Migrants (See Table 4.1). The categories identified in Barriers to Seeking and Maintaining Health included: Financial Concerns, Difficulty Obtaining Care, and Communication Issues. The theme of Social and Cultural Factors Influence Health-seeking included the categories of: Use of Traditional Chuukese Medicine, Lack of Preventive Care, Confidentiality Concerns, Feelings of Mistreatment, Role of Chuukese Women and Cultural Influences, and Educational Needs. All key informants identified education as a major influence on the health-seeking behaviors and health maintenance abilities of the Chuukese migrants in Guam. The category of Educational Needs included the subcategories: Health Education, and Lack of Knowledge of Health, Social, and Educational Systems in Guam. The theme of Political Influences Affecting Migrants was described through the category of Urgent Desire for Change. This theme was constructed from key informant and focus group participant data.

Table 4.1 Themes, Categories, Subcategories

<table>
<thead>
<tr>
<th>Theme</th>
<th>Categories</th>
<th>Subcategories</th>
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<tbody>
<tr>
<td>Barriers to Seeking and Maintaining Health</td>
<td>Financial Concerns</td>
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<tr>
<td></td>
<td>Difficulty Obtaining Care</td>
<td>Lack of transportation</td>
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<td>Long wait times in health care facilities</td>
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<td></td>
<td>Communication Issues</td>
<td>Inability to communicate with health care providers</td>
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<td></td>
<td></td>
<td>Mistrust resulting from communication barriers</td>
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<tr>
<td>Social and Cultural Factors Influence Health-seeking Behaviors</td>
<td>Use of Traditional Chuukese Medicine</td>
<td></td>
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<td></td>
<td>Lack of Preventive Care</td>
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Barriers to Seeking and Maintaining Health

The most commonly identified barriers to health care by the focus group participants and key informants were: financial concerns (lack of health care insurance, inability to meet co-payment requirements), difficulty obtaining care (transportation, long wait times), and communication issues (inability to communicate with health care providers, and mistrust between patients and health care providers resulting from communication barriers). These identified barriers influenced the health-seeking behaviors of Chuukese migrant women. Several women commented that these barriers made it difficult to seek health care and most did not seek health care unless they were already ill. Only one of the 22 participants identified preventive care as a part of her health-seeking behaviors. The category of lack of preventive care will be discussed further under the theme of social and cultural factors influence health-seeking behaviors.

Financial concerns

When discussing barriers to obtaining health care, participants in four of the five groups identified the lack of health insurance as a major barrier. All key informants identified this as a
One Chuukese woman stated: “The insurance—that is very important. We cannot see the doctor if we don’t have insurance.” The women in her group nodded in agreement. In another group, a woman stated: “Yes, because the ones who don’t have insurance cannot go to the doctor.” This woman commented, “For us there aren’t any problems because we have insurance. Transportation is the one issue we face when trying to seek health care.” Only one group had participants who did not identify insurance as a barrier they faced.

All key informants also identified financial barriers as a major limiting factor to health-seeking behaviors. The primary focus was the lack of insurance; however, employment issues also arose in the discussion of financial barriers. “A lot of it is not having medical coverage. Not being able to pay to go see a doctor—that is the bottom line.” Key informant (K1)

The key informant echoed the same sentiment when asked what difficulties the Chuukese migrants have in maintaining good health: “Maintaining good health, bottom line is money. A lot of them are unemployed, unemployed (repeated for emphasis by the key informant).” Key informant (K1). Two key informants also described this perception regarding insurance and employment; one was a social worker in a health care agency, while the other was a case worker in a social services agency:

They don’t have insurance; they don’t have insurance because they lack jobs. For example, the husband will be working for a construction company that doesn’t provide medical insurance, or they work side jobs and don’t have health insurance. So, most of it has to do with health insurance, not having health insurance. Key informant (K7)

From the social standpoint, they don’t have enough money to get their medicines but they don’t know enough to apply for MIP [Medically Indigent Program] or Medicaid….and
because a lot of them have just arrived on island before they come and seek medical attention, they’re not eligible to receive MIP until after 6 months and the private entities don’t take self-pay patients so they end up here. Key informant (K4)

Another key informant described the issue of finances in more detail:

In maintaining good health, it goes back to the other question. Money. In order to be healthy, you need money. It is expensive to be healthy. It is expensive to eat right. It’s expensive to exercise sometimes. It’s expensive too, and if you have a chronic disease like diabetes or high blood pressure, you have to maintain your medications, and so if the money runs out, you can’t afford to get your medications. Then the health care runs out and they don’t necessarily continue with what they need to do for themselves. Some of my clients don’t have power and water. Sometimes they don’t have refrigeration and so canned goods are the primary things they buy. It’s easy to go to McDonald’s and buy a hamburger for a dollar rather than cook something that is healthy, so that is an issue. Key informant (K2)

Several women identified the issue of co-payment as a financial barrier. Although they may have insurance, they cannot afford the co-payment required for some services. This concern regarding co-payments was voiced in several focus groups and by key informants as well:

For Medicaid, they tell us how much to pay for co-payment. For example, if the medicine costs $20, they would pay $10 and I would pay $10. For that, we wait until we have money, but when we have the money the prescription expired already because it’s been a long time that we’ve been holding onto it. Then it’s useless for us to buy the medicine because the prescription is expired already, we had it for a long time and we don’t have money for it, but if we do have money we get it right away.
Another participant echoed this concern, “Another problem is when they give us prescriptions for medicines. We have to go to the private pharmacies. And if we don’t have money, what are we going to do?” This problem was described again by another woman who stated, “Even when we go to the public clinic for a checkup, they still give us prescriptions for medicines that we have to get from other pharmacies. If we don’t have money, we can’t get the prescription.”

**Difficulty obtaining health care**

When the women described the barriers, several issues surrounding problems accessing care were repeated in all five focus groups. The researcher labeled this category: difficulty in obtaining health care, with the subcategories of lack of transportation, and long wait times in health care facilities.

Many of the participants described the problem of transportation as one of the main barriers to seeking health care. Women in each of the five focus groups identified this barrier. When asked what the main barriers the women face when trying to obtain health care, one woman replied, “If I don’t have transportation to go to the clinic then I cannot go.”

One woman who reported having private insurance coverage described transportation as the only barrier to her and her family’s health-seeking behaviors:

For us there aren’t any problems because we have insurance, except transportation is one issue we face trying to seek health care. Now our car is broken down. So now I have to cancel my appointment tomorrow. I never ride on the public transit. But I think last year when we called transit, they told us to walk down to the main road. The main road with the bus stop is approximately a 20-minute walk on a dirt road, with no sidewalks or trees to provide shade from the direct sun. The women described the public transit
as unreliable and too far to walk. The bus stop does not have a shelter for the women to sit and wait. Six of the seven key informants cited obtaining transportation as a barrier that arises frequently when working with Chuukese clients in their health settings:

And if they try to go to public health, they need to arrange their ride. And maybe they have trouble getting to Public Health during the hours that they’re open. They may not have vehicles available when Public Health is open. Key informant (K4)

And then they always say that the problem is I don’t have a ride. It is always a transportation problem. They will say I didn’t have a ride to come into the clinic. Key informant (K2)

When asked for suggestions to improve care, the issue of transportation came up again. One focus group participant who reported having transportation, but related to the difficulties of those without adequate transportation stated:

So these are the main things that we think are most needed and could help improve the health care delivery to the Chuukese people: to have health assistance through health insurance, translation services, and other possible solutions for the people with no means of transportation such as providing buses in order for them to reach the clinics.

Another participant described the issue of access to pharmaceutical services. The women live in a village that requires a 45- to 60-minute drive to reach the pharmacy and they identified transportation as a major barrier to health-seeking behaviors. The women reported that the only pharmacy that serviced clients on public assistance programs was located in a northern village. Previously, clients could obtain pharmacy services at multiple locations in various villages around the island. Private pharmacies were not accepting patients covered by the Medically Indigent Program, however, because of difficulties receiving payments from the local
government for patients on welfare:

Before they can give us a prescription and we can go anywhere, like a drug store in Agana. Now we have to go to the pharmacy in Dededo. We have to get the prescription and the referral. Before, we used to go to any pharmacy and they accept MIP. But now, no more. Since maybe three months ago. If Dededo is closed we can go anywhere, but if it is open we have to go there for the pharmacy. We used to go to a pharmacy close by our home. But now it is very hard for us to go to Dededo. Sometimes we cannot go right away because of transportation. Sometimes we have to wait up to three days to get a ride to take us up to the pharmacy.

The woman explained that the availability of personal transportation is difficult because of other family members working and needing the vehicle for work. She must wait until a family member has a day off from work before she can use the vehicle to obtain her prescriptions. In one particular instance, she waited three days before she could fill her prescription. She lived in a southern village and stated it takes an hour for her to drive to the pharmacy.

A subcategory identified in this category of difficulty obtaining health care included long wait times. Women in four of the five groups identified long wait times when trying to obtain care in the hospital or clinic settings. Women expressed frustration with the long wait times and perceived them as excessive. One said, “And another thing, I am so tired of going to that hospital because if I go there in the morning, I will be there until almost nighttime before I am finished.” Another woman in the same group chimed in: “maybe 5 or 6 hours to wait.”

When describing their experiences at the emergency room, the women perceived that the long wait times were an indication of lack of concern on the part of the health care workers. The excessive wait times without explanation from health care providers created a perception that the
women had to wait longer than others because they were Chuukese, or because they could not communicate in English. The topic of mistrust emerged. Mistrust will be discussed further under the category of communication issues. The following statement described the long wait experienced by one woman in the emergency room:

That is one problem, the long wait. It seems like they don’t care about us. We go in and sit from morning to afternoon, we get hungry, cold. One time I came and waited until almost night. I came by and asked the nurses how long it would take. They would reply, go back and have a seat and just wait. I almost just walked out. My son brought me to the emergency room. He was shivering from the cold so he had to go and wait outside in his car. It was a long time to wait.

A key informant described the long wait relating it to the lack of insurance:

Because you know when I go up to the hospital or the clinics, I see them waiting in long lines. You know, when you have to wait all day, and then they say we are closing at 5 and then you have to come back the next day. That is very frustrating. But if they have their own health insurance, they can walk into a clinic, anytime, anywhere. They don’t have to go to the hospital or the public clinics. They don’t have to wait in long lines. Key informant (K1)

Communication issues

A major category emerging in all focus groups and with all key informants was the topic of communication issues. Women in all groups, as well as all key informants cited communication problems as a major barrier. This category of communication has subcategories identified as inability to communicate with providers and mistrust resulting from communication barriers. Several key informants noted the lack of education in English in their country, thus,
many Chuukese are non-English speaking or have limited English proficiency on arrival in Guam. The English language proficiency of students from the Freely Associated States (FAS) attending schools in the state of Hawaii was described in a briefing by the Pacific Resources for Education and Learning (Heine, 2002). In many schools in the FAS, the home language is the primary language of instruction from the first to third grade. The use of English as the medium of instruction occurs gradually in the fourth grade and continues throughout high school (Heine, 2002):

The barriers could have a lot to do with the language. A lot of the families that migrate to Guam or out in the U.S., they lack English speaking skills. In our islands, Chuuk, just to be specific, education is not mandatory. So, you could grow up from birth all the way to when you are old, not having an education at all. Or you could just get into elementary school, attend up to the third grade, or the fifth grade depending on your family. Your family could decide that you should stay home. They decide for their own personal reasons. That’s a very much limited education. Key Informant (K7)

Inability to communicate with providers

Participants in all groups described their inability to communicate with health care providers and with workers in other settings such as social services and public assistance programs. Many women reported the need to bring a family member who could speak English with them, or if no English-proficient family member was available, the women spoke of trying their best to communicate. The women described the difficulties faced because of to the language barrier and how they attempted to communicate. One woman even offered this statement, feeling workers treat the Chuukese differently because of the language barrier: “Maybe they skip us for those that speak English.” Another woman stated: “It is good for those
who speak English, but for others it is hard. They have to bring someone who can translate with them.”

Another woman voiced her feelings regarding the language barrier:

Having a translator is very important because we go in and we have a hard time trying to tell doctors what the problems are, not knowing how to say it in English. I can only say simple words and describe simple illnesses. But when it comes to having bigger issues I don’t know what to say.

One woman, whose grandson had been in the pediatric unit, shared this experience in which her grandson was admitted to the hospital, but the child’s mother could not speak English. “My grandson—when he was admitted, someone that could speak English had to go and stay with the mom and child in the hospital. Maybe, that’s why it should be the first priority. So having a translator would help.”

A key informant voiced the concern that Chuukese have the right to be given the opportunity to understand what is being said to them. This key informant is Chuukese and emphasized the word “we” in the following statement. “They have the right to understand. We have the right to understand and to communicate.” Key informant (K6)

Several women expressed the perception that the language barrier prevents some from seeking health care and offered the suggestion that translators could improve the situation and perhaps make it easier for Chuukese to obtain health care. One woman stated, “It is important to have a translator because some people don’t go to the clinic or the hospital because they don’t understand English.”

In another focus group, one of the women echoed concern that language affects health-seeking behaviors: “We could have a translator. Maybe that’s why some of the Chuukese don’t
go see the doctor; because they have a hard time talking to the doctor. Maybe if there are translators then maybe it would be easier for them to go and seek health care.”

Yet another woman empathized with the Chuukese who cannot speak English:

I feel sorry for the dental clinic. Some Chuukese, when they come, they can’t understand. When they give them paperwork to fill out, they don’t understand. They don’t know how to fill out the paperwork. Some of them just take the papers and leave. Some ask other Chuukese to help them. That’s the problem.

A concern brought up by two key informants was that Chuukese often respond “yes” even if they do not understand what is being said. One informant compared Chuukese to other Micronesian ethnic groups describing Chuukese as more likely to say “yes” regardless of whether they understand. “There are some that understand more than others. The Chuukese are more likely to say yes, yes, I understand—even when they don’t.” Key informant (K4):

That’s the other thing about Chuukese culture…everything is yes. Because that is just polite, that’s just proper. Even if I speak Chuukese, sometimes they’ll say yes. That’s why I prefer the translators because I can ask are you sure they understand. I can really ask if they are going to do this. Sometimes I tell them to do step one, then call me, and I’ll tell them to do what step two is, and then I’ll tell them what step three is. Key informant (K2)

Another key informant described the behaviors of Chuukese and the language barrier. This comment also illustrated the need for translators:

They don’t come out right away and they don’t ask questions. Especially if they are not familiar with you, they don’t really feel comfortable with you, but they just say yes, yes, but in fact they don’t know. That’s really another issue, and that’s one of the reasons we
have an interpreter so that they make sure they do understand what they are coming here for and we can find out what their health problem is. Key informant (K5)

All key informants cited language as a major barrier for the Chuukese migrants. Key informants recognized the problem and described the importance of having translators available in health care settings. Only one of the agencies in which the informants work had hired translators for the purpose of assisting this population. The only civilian hospital on Guam does not have translators in the emergency room; however, employees who speak Chuukese may be called upon when needed based on the health care worker’s judgment. This is the current situation at the local hospital:

I know we have three employees that are Chuukese. They work in different jobs. We don’t have a dedicated translator. But there is a list given to them [health care workers at the hospital], a list of translators. We do have people in the hospital that serve as translators. We don’t have one that sits there in the emergency room. Key informant (K4)

The health care system in Guam continues to rely on family members or friends to translate, if available. The hospital utilizes Chuukese employees to translate when the health worker feels it is necessary. These Chuukese employees are not hired as translators, but are hired into other job categories. They are utilized as part of a translator pool as needed. The judgment to obtain a translator rests with the health care worker. The following comment speaks to the ongoing problem of the lack of translators:

I have some educational materials translated into Chuukese, but some of them don’t read Chuukese so my teaching is mostly done verbally. So it works well when they bring a translator. We actually have a Chuukese employee in our school so sometimes I’ll grab
her out of her classroom and have her help me translate if it is that important to me. Key Informant (K2)

A key informant described an incident that may have been avoided had adequate communication occurred. Although a translator was not available when this incident occurred, this particular agency currently has a Chuukese employee hired to assist in the area of Women’s Health services:

One time we had a lady come in for a Pap smear. She came in with her husband so I asked: “You and your husband will go into the room together?” So, first of all, they didn’t know the reason they were coming in. Yes, they knew they were coming in for the Pap smear, but they didn’t know what a Pap smear was. So I had to explain it to the patient. I said, “The doctor’s going to check your bottom, he’s going to put you on the table and he’s going to open your legs.” They just got up and left. They were not made aware of what a Pap smear was before they came in for the appointment. Sometimes they don’t ask questions, so you just assume they know. Key informant (K5)

One key informant empathized with the Chuukese describing an experience at a social event that caused him to reflect on the situation concerning communication barriers. “I was looking at some of the Chuukese; they do not understand English at all. And here we are, speaking English to them.” He went on to describe an experience he had to illustrate the problem of language comparing his own experience to that of the Chuukese migrants:

I’ve been to a conference in China a few years ago. At the conference, they were speaking in Chinese, and here I was, a member of the conference, and they were speaking in Chinese. There were no translators, and I was thinking, Wow. So, the Chuukese, who
are in Guam, they cannot understand English, just imagine if we are in their shoes. How
difficult it is. Key informant (K1)

**Mistrust resulting from communication barriers**

Another important finding was the language barrier and miscommunication occurring
between clients and the health care providers. This miscommunication contributes to feelings of
mistrust perceived by the women. One woman gave an account of her experience in the
emergency room of the local hospital. She interpreted a physician’s comment literally, and this
miscommunication led to her mistrust of the physician and treatment prescribed. This incident
provoked strong feelings and the woman brought it up several times during the focus group:

The skin all over my body was very swollen. I went to the hospital and the doctor said
that is an infection—just give the trick. I don’t know what kind of trick. I was praying
and asked God to touch his heart so that he can feel how much pain I have. That is the
only thing that I did that night. Then they gave me the paper for the medicine. I went to
the pharmacy, I bought the medicine and it did not work. There is no use for me to go
back to the hospital. They said they are going to do the trick. So what kind of trick are
they going to do? She paused for a minute, and then went on. They really said that. That’s
the word coming out from the doctor’s mouth. “The trick.”

And later in the focus group, she again referred to the incident:

And the second time I went there last April, and the doctor said the sores are an infection
and we’re going to do the trick. I don’t know what kind of trick. That’s the thing that
stuck in my brain.

Perhaps the practitioner used an idiom such as “This should do the trick” referring to the
medication he prescribed to treat the skin ailment. The researcher cannot verify this; however, it
is apparent that the perception of the woman was that the practitioner was going to play a trick on her. This led to distress for the woman and mistrust of the practitioner. The use of idioms and sayings that are not understood by non-English speakers can lead to miscommunication. In directions for the use of translators in health settings, the British Psychological Society (2008) cautioned that when using axioms or sayings, be aware that if the saying does not make literal sense, it should not be used. The previous comments by the participant when the physician used the word ‘trick’ illustrate the complexities of language and powerfully demonstrate how miscommunications can occur with distressing consequences for the non-English speaking client.

Many women described how the language barrier, coupled with behaviors they perceive as “poor treatment” by health care workers led to difficult situations. Several described situations in which case workers did not allow others with better English-speaking abilities to assist them. One Chuukese woman relayed her experience speaking with obvious emotion in her voice and face:

What about the caseworkers in food stamps and welfare, can we talk about them too?
Because I helped one lady, she lived with me before. And she was really crying because she cannot speak English. The case worker was screaming, and I tried to help her to talk to the case worker but the caseworker told me “You know what, she has to speak English.” I tried to explain that she cannot speak English. The caseworker replied, “You are done, you cannot help her, and you can get out.”

Another woman voiced a similar experience when describing her experience trying to apply for food stamps:
It shows that the lady does not want to help us Chuukese. She will help only those who can speak English well enough to answer her. Unlike those of us who don’t really know English—we would just answer yes/no to whatever and they will not help us understand. They wouldn’t care and won’t bother to help us. The first caseworker that helped me apply for food stamps was a lady. That lady, she was really mean. She didn’t want anybody to help me. My niece came with me to help me. The caseworker told her to leave. She said nobody should help me, I should do it myself.

These examples illustrate the difficulties of communication in health and social service settings. The women perceived they were mistreated and some women perceived this as a consequence of their inability to speak English. The category of feelings of mistreatment will be discussed in detail in the following discussion of the theme: Social and cultural factors influence health-seeking.

Social and Cultural Factors Influence Health-seeking Behaviors

Women described various social and cultural factors that influenced their health-seeking behaviors. The categories identified during data analysis included: use of traditional Chuukese medicine, lack of preventive care, confidentiality concerns, feelings of mistreatment, role of Chuukese women and cultural influences, and educational needs.

Use of traditional Chuukese medicine

The women had differing descriptions of when they would use traditional Chuukese medicine. Some women described using traditional Chuukese remedies when Western medicine did not cure them or their family members. Other women reported using traditional Chuukese medicine before attempting treatment with Western medicine. Most women referred to use of oil and leaves to treat their children suffering from fever or colds. One participant explained: “For
example, they use it for colds and fever, Chuukese use medicine specifically made for the illness.”

Several women described using Chuukese medicines for their children during times of illness. One woman commented, “We use it only for our babies. When they are sick, then we use Chuukese medicines.” Another viewpoint was, “Whenever they [children] get sick we don’t take them to the doctor. We know that we can cure them. We give them Chuukese medicine.” One participant provided this description:

We get leaves from the trees (women laugh). Sometimes we just rub it on the children when they are sick. We just make an ointment with the oil and leaves. We don’t use baby oil, we use coconut oil. Sometimes, when the children get a fever, we don’t give them medicine [Western medicine]. We just give them Chuukese medicine. Sometimes we can tell when the Chuukese medicine will cure it.

Women in four of the five groups reported using some forms of Chuukese medicine to treat their family members. The women in the group who reported not using Chuukese medicine did verbalize their understanding of how others use Chuukese medicine: “As for me, I don’t use Chuukese medicine. But I know that the Chuukese that do use Chuukese medicines will go to the hospital and when they are not healed, then they would try to use Chuukese medicine.”

Another participant from a different group described a similar practice:

When we go to the hospital and our illnesses are not cured or healed, then we would use our Chuukese medicine. It is a gift passed down from the elders. They can just see what the problem is and know what type of Chuukese medicine to use to cure the illnesses.
One of the key informants also expressed the perception that the lack of health insurance may be a factor influencing whether Chuukese in Guam use Chuukese medicines. Chuukese medicines may be used as a first attempt prior to seeking Western medical care and treatment:

They don’t have health insurance; so they would try Chuukese medicine, herbs, and other means before they come in to the clinic. Sometimes they do come in before using Chuukese medicine. But for those that use Chuukese medicine first, sometimes the Chuukese medicine doesn’t work. So that’s when they come in; sometimes their condition is already worse. Key informant (K5)

When discussing the use of traditional Chuukese medicine, one key informant described a dramatic example of the use of Chuukese medicine to treat a child rather than taking the child into a clinic or hospital. The key informant also related the use of Chuukese medicine because of financial constraints.

It goes along with dollar signs and prioritizing. Sometimes making the truck payment is more important than buying the medicine. And then a lot of times, my Chuukese families try and do their natural remedies, herbal remedies, cultural remedies, first, before going to seek Western medicine. And sometimes it works, and sometimes it just made it worse because then they have waited too long. Key informant (K2)

I’ve had kids that have had to break and reset a bone because they waited a week and they are trying to repair the damage by massage. They call in a massage person to massage it back into place. I’ve had a child with a femur fracture where the kid ended up in traction. He didn’t come to school for a few days. And the principal and I went to find him. We drove out into the community to look for the family. We found him, and his right thigh was twice as large as the left. And I said OK, if you don’t get him into the
hospital in the next hour I’m just going to call Child Protective Services and they’ll take him. He had fallen out of a tree and landed across a root and broke his femur. And so, and he was lying on the floor, he was completely naked, he was urinating while lying down. He couldn’t get up. I went to the house, I said you’ve got one hour. And I told my boss they’re going to have to take him to surgery and reset the bone. He ended up in the hospital for a month. And the whole thing was: Why didn’t you take him? I didn’t have a ride and I didn’t have money for the hospital, so they were massaging it. Key informant (K2)

**Lack of preventive care**

A finding that emerged across all focus groups and in the key informant interviews was the category of lack of preventive care. The women reported that they do not seek preventive care services. Even women who reported having insurance did not seek preventive care. Only one woman who was pregnant at the time reported going to the clinic for regular visits, not just during times of illness. The concept of preventive care is not a priority for these women. However, all women with children reported taking the children in for their immunizations and the women reported seeking prenatal care when they were pregnant. This behavior was typical of the women as their major concern was for their children rather than their own health care needs. It is also conceivable that they lacked understanding of their own health care needs. In Chuukese society, the role of women includes the primary responsibility for rearing the young children (Hezel, 1992). The focus on the health of the children is part of the cultural role of women.

The lack of preventive care is related to the lack of general education and health education identified as a theme by key informants. Several comments by the women illustrated
the health-seeking perspective of the women. One woman emphatically stated: “I never go to seek health care for myself.”

Another woman, who identified herself as having health problems, still did not seek preventive care and only sought care when ill. She stated, “I, myself, have some health problems. But I don’t go to clinics. I do take my kids to the clinic, but I don’t go for myself. I do feel ill and sick sometimes but I never go for checkups.”

Another participant described similar health-seeking behaviors. When asked about health problems affecting her or her family, she stated she has high blood pressure. “I don’t take any medicine for it. I only take medicine when I go to the clinic and they tell me it is high. I go to the clinic when I am sick and don’t feel good.”

When asked to describe when to seek health care, one woman in another group reiterated the sentiment that health care is obtained only for the children’s immunizations and for prenatal care. “I go to the clinic for my kids to get their shots,” she said, “And I go to the clinic for checkups, like a prenatal checkup.”

When asked to describe when to seek health care, another woman who reported having insurance through the Medically Indigent Program (MIP) replied, “Only when I’m sick.” In another focus group a woman had the same answer stating, “I only go when I am sick, not for regular checkups.” Participants who reported having health insurance related that they would attend free outreach activities, but sought health care only when ill.

“We will go to the clinic sometimes when we get sick or have health problems. Sometimes we see on the media or in the newspaper what health services are offered to the public and we would attend as well.”
One woman also described the difficulty making appointments explaining when she would seek healthcare:

There is nothing for me to go to the clinic for because I don’t see the doctor and I don’t need to go to the doctor. The last time they came here [during an outreach to the village] to check, that was the time I realized I have a sickness. It is hard for me to go down there to the clinic. I went down there to the clinic and tried to make my appointment so that I can see the doctor and I just took off. I left because the lady just told me you cannot make an appointment now because it is already full. Until now I did not go back and this was ever since last year.

A key informant identified this lack of preventive care as an issue of concern and recommended further assessment and increased education of Chuukese women.

Um, [long pause], it’s just that in women’s health and family planning, it’s not very busy. We don’t really see a lot of Chuukese women come in for family planning and women’s health. I don’t know why. They do come in for prenatal care when they are pregnant. Some do, some don’t come in for prenatal care. But only if they’re pregnant do they come in. But in terms of family planning and women’s health, you don’t really see that many of them. But maybe that’s something we need to target with the population. But before we do that, we need to find out if that’s something that they would do, something they would be interested in. We do see a lot of Chuukese bringing their children in for child health concerns, but not women’s health in terms of family planning. And so for family planning and women’s health, Pap smears, sometimes they don’t understand. I mean we have to spell it out. And so, for things like that they need more education. And you can conclude that they do need a lot of orientation in terms of their health and then
the more we teach them, the more it will help. It will help everyone else who is involved in their care. Key informant (K5)

Confidentiality concerns

Confidentiality concerns emerged as a finding initially verbalized by focus group participants and reinforced by two of the Chuukese key informants. When women gave suggestions for how to improve care to Chuukese migrant women in Guam, many stated that they recommend providing Chuukese translators. Several women, however, described concerns that the translator may not keep information confidential. Chuukese women described the concern that when speaking with other Chuukese about their health concerns or other private matters, the Chuukese translator would not maintain confidentiality. The first woman to identify the issue of confidentiality was a Chuukese woman who had worked as a nurse in Chuuk but moved to Guam to care for her sick, elderly parents. When asked what suggestions she could give to improve care for Chuukese migrant women in Guam, she answered, “You need to have translators.” But then, smiling, she went on to explain:

Even though they want to have someone translate, some Chuukese don’t want other Chuukese to know their problems. It is important to have what you are doing right now, going around educating. But we need help with translations so the people could better understand the importance of health care. But the problem is the possible leak of information of confidential health problems by the translators.

Another woman in her group further clarified: “But with the health problems the translator would find out people’s illnesses and sickness. Then they would go tell others about their health problems and people would not want to come for checkups.”

A key informant gave this description of the confidentiality issue.
They keep things to themselves. It’s easier to talk to an outsider. Do you know why?
They never told you? Because if I know you or you know me, and we start talking, and I find out things about you, then I’ll be able to go talk about you. That’s what they don’t like. Yeah, but a stranger—they don’t care, because that stranger’s not going to talk about them to the people they know. Key informant (K3)

Two of the Chuukese key informants explained that the understanding of confidentiality as a legal duty in the United States health care system is a concept foreign to Chuukese migrants in Guam. Both key informants emphasized the need for translators to understand confidentiality and to clearly explain this to the Chuukese clients in order to gain their trust when a Chuukese interpreter is involved:

You need to make them understand that if that person is hired to be a translator, they have to sign an oath of confidentiality. That’s very true. So that’s why, when they come here, there’s some of them who are withdrawn because I’m a Chuukese. So I have to be flexible, I have to show them that in order for them to have confidence in me, they have to know that this is my job and I can get fired if I don’t maintain confidentiality. We need to explain to them because in Chuuk, we have no confidentiality. In our small island everyone knows everybody’s business. No matter what, there is no confidentiality. When we’re in Guam, our story today can stretch and it’s already in Chuuk, it’s faster than the airplane. Key informant (K7)

This concern and lack of confidentiality in Chuuk is so deeply ingrained, that although one of the key informants is college educated and works as a translator on Guam, she still has the deep concern that a Chuukese translator may not keep her information confidential. She related a specific incident:
There was one time that I went down to Court, and there was this lady from Polowat [a Chuukese island], I thought she was a social worker, but she’s in the juvenile section. And they sent her to me to be my translator. She came out and she was introducing herself. I said, “You’re from Chuuk, I don’t need a translator.” I said, “Do you mind? You are Chuukese, I’m Chuukese and we both are English speakers. If they’re giving you to me because they think I’m Chuukese, and they think I don’t understand the language, then I don’t need your help because I speak English.” I requested for someone else to assist with the situation. And she had to explain to me saying, “I know where you’re coming from.” And that’s how we think automatically, but I know better. She was very helpful and I really appreciated her, even though I rejected her at first. She was very much understanding and had compassion for how I felt. She explained that she knows she is supposed to keep everything confidential. She even said, “Even my spouse, I don’t share anything with him.” Key informant (K7)

The researcher probed further asking the key informant to elaborate on her feelings regarding use of Chuukese translators. She provided further explanation that Chuukese translators have to explain the concept of confidentiality and the legal requirement in Guam for health care workers to keep information confidential. This detailed explanation is vital in order to gain the trust of Chuukese clients. “Yes, it is a very strong feeling. But I felt that she explained it. If we are going to be translators, we have to explain confidentiality to our clients.” Key Informant (K7)

When the researcher explored the issue with the other focus groups upon verification of findings, the women immediately expressed their sentiment that confidentiality is a concern when using a Chuukese translator. The women were immediately open about their concerns
regarding confidentiality, speaking in a manner so frank and open that the researcher had the sense this was common knowledge in the Chuukese community. The issue of trust emerged and the need to trust the translator before divulging private information was clear.

When asked about having a Chuukese person translate one woman immediately commented, “I want a translator, but if I can’t trust them, I won't go.” Another participant stated, “We cannot express everything [to a Chuukese translator].” The issue of trust was repeated by another participant in a different group who stated, “It has to be someone I can trust, like an older lady, or someone from the Church. I don’t know about the younger generation, if I can trust them. It has to be someone I trust.” Another participant from a different group stated she wanted a Chuukese translator, but qualified it with: “If I trust them.” This was a theme echoed across all groups.

**Feelings of mistreatment**

Women described feelings of being mistreated and the perception that they were being treated differently because they are Chuukese. They described difficulty in obtaining help in social and health care settings. Several women used the word “afraid” or “scared” when describing how some Chuukese felt regarding some health care workers. They described the fear as a barrier to health-seeking behaviors preventing some Chuukese from seeking help.

“They’re so mean, the health workers in the clinic. The health workers are very mean. When I took my mom and dad to the clinic they were so mean and not very helpful. They were taking their time.” Another woman added to the first woman’s comments, immediately adding, “We can tell by their faces that they are mad. Some Chuukese won’t go to the clinic because they’re scared. Just like me, when I go to the clinic I am scared to look at their faces.”
A woman in another group denied experiencing poor treatment from other public clinics, including the clinic her and her family members use for their routine health care needs. She did have a similar negative comment about one clinic, but not about all the public clinics. “No, most of the clinics we have been to—they have been very helpful to us. But I don’t know, sometimes I am scared to go to this other clinic. When we go, we have to wait and they don’t want to answer our questions.”

A mistrust of health care workers and the health care system resulted from the women’s perception of poor treatment. The communication barriers described earlier also contributed to this lack of trust. The women vividly described several examples illustrating the feelings of mistreatment and the lack of trust. One woman stated:

My food stamps application was held up for seven months. Then my sister came with me to help because she speaks more English. We went to the head of the food stamp section and called the caseworker. My sister asked to see a supervisor. Then they found my application and processed it right away.

Another woman in the group gave a similar account of her experience:

It also took a year to get my food stamps processed. My caseworker took my application, put it under the rest and never worked on it. The next time I came I told another lady about it. She asked me how long it had been since I turned in the application. I said one year. She said we’re going to meet the supervisor. And just that day she helped me. They pulled out my application. They had looked for it but couldn’t find it. They found out that the caseworker stored it in her files and did nothing about it. The supervisor then pulled out my application and that day they processed it. They told me just this evening that I can use it.
One woman, when relating an experience while waiting for care at the emergency room, described the lack of communication she perceived as poor treatment: “Last year I had a fever and threw up, I felt dizzy. I went there from 12 o’clock midnight all the way to 6 o’clock in the morning. And then the doctor came to check me. He asked the nurses how come they were holding me in the emergency room.” She went on to describe that she felt they were not treating her well. She was concerned they may not provide good care. They were talking to each other, but not communicating with her. “I felt bad; I just hoped that they would do the right job. And they didn’t even check me, or give me something. They just talking, talking to each other.”

Another woman explained, raising her voice as she described her experience:

Two weeks ago I went to public health. I applied for food stamps, gas, MIP, and Medicaid for my daughter. One of the caseworkers was no good. And I just took the paper and I said, “Why you don’t respect me? Why do you ask a lot of questions? You told me first that I can apply for MIP.” I told her to just give me the application and I threw it away. And I just walked out.

She went on to describe what occurred before she walked out, speaking in a raised tone of voice and speaking more rapidly than before:

The caseworker then asked me to give her my passport and then said that I am not eligible. I had to come back after 6 months. Then I asked her why she had to ask a lot of questions before, when now you just told me to come back after 6 months. But yes, I did check up on those things in my application.

One woman described the belief that she is treated badly at times because she is Chuukese. The Chuukese women are often identified by the long, floral skirts they wear as part of their day-to-day attire. The colorful skirts are a source of pride and cultural identity (Blair,
When describing her experiences and thoughts on being mistreated, she stated in a low, sad tone of voice and with her eyes facing downward: “Sometimes I say to the women ‘Let’s not use our skirt so they won’t know I’m Chuukese.’ Sometimes I go out, I wear pants so they don’t know I’m Chuukese.”

This statement powerfully demonstrates the concept of marginalization and not wanting to be identified as a member of a marginalized group. This is a significant situation, because Chuukese women have a strong cultural tradition of wearing long skirts. The lower body including the groin and pelvic areas are considered “private” and not to be shown by wearing short skirts or pants. Chuukese women are expected to maintain a modest appearance and should not demonstrate any behavior that may be viewed as having sexual connotations. This expectation is influenced by the incest taboo so strongly engrained in the culture and previously described in Chapter 1. Moral (1998) further described the Chuukese perception of women as hypersexual beings, and in order to maintain the incest taboo, a woman must maintain modesty in appearance, clothing, actions, and even in her presence.

The concept of a woman’s presence and the need to maintain the incest taboo is complex. Women are expected to avoid places where their brothers congregate, including anyone in the clan who may be perceived as a “brother.” This avoidance behavior is difficult and awkward, particularly when Chuukese relocate to Guam and live in apartments or homes not set up in the manner of traditional Chuukese dwellings (Bautista, 2011). Chuukese dwelling areas included separate sleeping houses for men. Chuukese are expected to avoid elimination of bodily wastes in the presence of siblings of the opposite gender (Marshall, 1979). Bautista (2011) described the difficulty faced by women when they need to shower or go to the bathroom. Maneuvering around their brothers is difficult, and for some, so unmanageable that they leave their home or
apartment and go to a public restroom. The complex incest taboo and norms governing female behaviors affected the lives of women. This example of the Chuukese woman deciding to wear pants, rather than her traditional skirt is powerful. The statement by the woman participant is important when viewed within the cultural context. Her nonverbal behavior of lowering her head as she spoke further emphasized to the researcher the significance of her comment.

When key informants were asked if they ever experienced Chuukese migrant women being marginalized or stigmatized, all but one key informant reported witnessing marginalization. The reaction by key informants to this question was interesting. Key informants were quick to answer most questions; however, this question caused them to pause before answering. Several hesitated to give an answer, even verbalizing feelings of embarrassment to be part of a system that marginalizes or stigmatizes the Chuukese.

One key informant, rather than answering the question directly, described his perception. Again as I said, they’re staying in area X because that’s the kind of opportunities they have. They will not stay in area X if they have better opportunities. So the more and better opportunities they have, the more likely that they can stay in good houses and get good transportation. They’ll be more open and be a part of the community. I’m sure all immigrants, they go through that process, when they come. So once they go through the process and become educated, and more familiar with the places, they will know what it means to be living in America. Key informant (K1)

Later, he continued to describe the situation, almost implying that the Chuukese are marginalized now, but won’t be for long:

I’m certain if they understand the system, and if they communicate well, they will make a difference. And once they start working, they will earn respect. But as long as they
continue to be dependent on public assistance they will continue to have problems. Key informant (K1)

Marginalized populations lack control over the resources available to them and experience limited opportunities. Social factors in the mainstream culture may perpetuate the view of marginalized populations as existing outside the dominant society. The marginalized populations have limited access to social resources such as education, health care, housing, and income (Burton & Kagan, 2005).

Although the key informant did not answer in the affirmative when asked if he ever experienced Chuukese migrant women being marginalized or stigmatized, the comments made reflected the view that Chuukese migrants experienced marginalization. The informant commented further, almost as if to give a solution to the problem of marginalization.

So we need these people to have that kind of dignity and respect. But they’ve got to earn it. It doesn’t just come easy. They have to work hard to get it and in the end they’ll celebrate. They will know what it means to be respected by others. Key informant (K1)

A nurse key informant, after pausing before answering stated:

Yes. Yes. I have, I have. They have come to me and told me the stories that they went to the hospital and they were sent home. And I’ll ask them, “With this? They sent you home with this? Why didn’t they do this? Why didn’t they do that?” And so it’s, for me, as a practitioner, I have to, in my mind, make sure that I’m not doing that. That I’m not looking at them as a Chuukese person, but unfortunately sometimes I have to look at them as a Chuukese person, because culturally, I have to accommodate their culture. But then I also have to educate them that they are in Western culture now and that is not how
it’s done here. There are some things that you have to adapt and change. And health care
is one of those sticky areas with them. Key informant (K2)

The key informant went on further to describe her perceptions of marginalization of the
Chuukese within the health care setting. She described her view that teachers in the school
setting may be less likely to marginalize the Chuukese than health care workers.

As part of the training to become a teacher, they are trained not to look at the child as
Chuukese, Chamorro, and Filipino. They are trained to look at them as just a child.

Teachers are taught to provide an education to all children regardless of their ethnicity.
And we do get some of that training in nursing school, but then when you’re at the
hospital and 75% of your patients are Chuukese, and then you start developing this
attitude that oh my God, another Chuukese person is coming in here that I’m going to
have to take care of. So, yes, I have observed poor treatment of the Chuukese by other
practitioners in my personal experience as a patient and then in my professional
experience as a nurse. And it’s something that I have to consciously make an effort to
avoid doing when I’m working with my clientele. Key informant (K2)

Another nurse key informant was hesitant to answer the question, but then went on to
explain her observations and perceptions of poor treatment and marginalization of Chuukese in
both community and health care settings:

Well, (hesitating) if I say that it’s true then I would be the one to blame because I’m
admitting that it’s true. But I observe it, and it’s not only in the clinic, it’s in the
community. It’s not only in the health clinic area, but other programs in the center. I can
only speak for the clinic because I’ve seen how they are treated; they treat them very
poorly. I can say that it’s a little better than maybe five years ago. Five years ago, or so,
Chuukese women didn’t really know how to speak up. Chuukese women didn’t really know where to go for help. So they just go in and wander in any direction. But so the clinic workers treat them poorly. And the workers tell them what to do. And the women, they just don’t talk back, and then they don’t argue. Instead, they will leave. Key informant (K5)

Not all informants hesitated when asked. This informant gave a quick and emphatic answer: “They are very much so. They are stigmatized. They are picked on.” This key informant gave further descriptions of marginalization experienced by the Chuukese.

I can see the way employees, like at the clinic, sometimes the way they act towards the Chuukese. They look out at the people in the waiting area and see the Chuukese. Some of the workers maybe don’t care. They look and think, oh, they’re just Chuukese. In some ways they are looked down upon. Key informant (K3)

So, you can sense it when you walk in to the clinic. You see that it’s all Chuukese people in the waiting area; and then you can see that whoever is the intake person or the clerk, you can see that they are not being friendly. When someone from a different culture walks up to them, they react differently. When a Chuukese person walks up to them they are treated differently. I see it, and I’m uncomfortable when I see that. They are marginalized. Key informant (K3)

The two Chuukese key informants also reported the perception that Chuukese migrants are stigmatized or marginalized. One key informant related a personal experience of marginalization as a Chuukese person when she sought health care for a family member:

I do feel that I am treated differently. I come across people that will talk like they know I’m Chuukese, but they don’t know I understand Chamorro. A couple years back, in the
90s, I brought my ex-husband’s uncle to the clinic, and this lady will never forget me.

There were a couple of them in the receptionist area. I went in and this lady said, in Chamorro, “Ai, this lady, she thinks she can bring all her family.” So I turned around and I said, “Excuse me, First of all, I am Chuukese, but I am also part Chamorro, and I very much understand every word you said, and second of all, that’s why you are working here, and if we are qualified, then why not?” Boy, she disappeared. Key informant (K7)

She later described a recent conversation with a fellow Chuukese employee regarding the public sentiment towards the Chuukese migrants in Guam:

I have a colleague here in Agency X, we were talking about the situation of the Chuukese, and she said that the migration is becoming a problem. It is already a problem. Sometimes we feel that, you know, a lot of Chuukese blame others. They say, “Oh, the people of Guam don’t like us.” Or we see negative stories of Chuukese in the media. Sometimes we feel that we’re putting ourselves down; we’re less than others. But that’s why I think that the ones that can speak out should speak out. We see what’s happening, and we’re concerned. Those of us with more experience in Guam, and who can speak English should speak out. We could have prevented the influx and the problems that we’re creating due to the migration. I guess we should have done something on our islands, as far as training and controlling the Chuukese moving into Guam. Key informant (K7)

When discussing marginalization, one key informant described the feelings of fear and mistrust she perceived in the Chuukese community. Her comments about the number of Chuukese deaths at the hospital, while not reflected by other study participants, speaks to the fear and mistrust that may be present in the community:
There is a lot of discrimination, even at the clinic and at the hospital, there’s a very big problem there. We have concerns at the hospital and we’re scared. We don’t know where to go. We’re scared to voice out what we want to say. We cannot voice our concerns. The main concern is at the hospital. I would prefer if there is an investigation into the number of Chuukese deaths. If I look at the number of deaths and I compare the different nationalities, what would it be for the Chuukese? But the Chuukese, every week there are deaths. I’m not talking about accidents or suicides; but those who go to the hospital for other diseases. We feel like we are treated differently. We’re not being treated like we’re supposed to be treated. We don’t deserve to be treated poorly. Key informant (K6)

During a return visit with a focus group for verification of findings, one of the women described a recent experience after her father had a stroke and was hospitalized for acute care and then transferred to a rehabilitation facility. Her comments reveal both positive and negative perceptions of care provided to the Chuukese. The perception of mistreatment because they are Chuukese was confirmed by her fellow group member:

They took good care of him at rehab. They even helped my mom by telling her to rest.

They kept him clean. They really understand the Chuukese over there. I think one of their staff is married to a Chuukese man. They were really nice to us, and took good care of my father. But at the hospital, they don’t take good care of the Chuukese. They don’t like the Chuukese there.

Another woman in the group nodded her head in agreement and stated, “We don’t trust them over there [at the hospital]. They don’t take good care of us. It is not just because we don’t understand them, but because we are Chuukese.”
Role of Chuukese women and cultural influence

The role of Chuukese women in Guam influenced their health-seeking behaviors. Issues of male superiority and gender norms within the Chuukese culture were significant influences in the lives of Chuukese women. The female Chuukese key informants described the role of women as subservient to the Chuukese men. In Chuukese society, men are considered superior, with women viewed as weak and needing protection by men. An important role of women, however, is that of the guardian of family unity (Moral, 1998). A male key informant shared this perspective:

I notice that that’s why it is always the women that are coming to us. When I say, “Where’s your husband? Is he sitting in the car?” And I tell them, “Go get him.” The women are the gophers. The man will sit there in the car and send the wife in. I drill the husbands. “Why is it you are sitting there and your wife is coming in here?” And I really get on them. I always feel comfortable with those kinds of things. I don’t let the culture intimidate me. I guess the men don’t mind because they sense that I am not really putting them down. I care, that’s why I’m attacking them. They know that I care about them. When I attack the husbands, the wife will be there smiling. It’s really funny sometimes. And they really like it when I scold the husbands. Key informant (K3)

Another key informant explained that some daughters are placed in the role of translator for the family if the daughter has been educated and has more English language proficiency than the father or men in the family. The daughters often have more confidence in interacting with the health and social systems due to this English language proficiency:

You know what, those women that speak out, they’ve gone through education. It is very common in a lot of Chuukese families, that they’re using their daughters and their sons,
mostly their daughters because those men, they’re higher than us ladies. So we tend to do everything for the family. Those men, they bring their daughters for things like translating. And because the daughters are more exposed to the system, and more educated, they’re not afraid. Not like the Chuukese that just migrated to Guam, or the ones that are not exposed to the system at all. That’s why you’re noticing that. But I guess, when they stay longer here also, they will be exposed and experienced. And in time, they will know what to do, even if they don’t have formal education, or very little education. They will be able to fill out their public health application and all the papers. They will be able to get in and out, in and out. So they will be able to say, “OK, so I can do it.” Key informant (K7)

The informants emphasized that Chuukese men are used to being treated as superior, but this may lead to culture clashes in Guam, where the majority of health and social service workers are not Chuukese and may not be familiar with the culture. One key informant described this culture clash when Chuukese men interacted with workers in the public school setting in discussing issues with their children:

With the school, you know, like I said before, the Chuukese men, the men are considered superior. We respect them. But the Chuukese men, when they go to the school, the workers sometimes treat them poorly. The Chuukese men don’t really feel like they’re treated according to the Chuukese culture. They are treated like… (mimics yelling). But us Chuukese women, we cannot yell at the men. We cannot raise our voice. We have to be (speaks softly) like our tone of voice, we cannot be like “Well, sir” (speaking loudly) But the workers in the schools should understand the cultures. Key informant (K6)
The gender difference or traditional gender roles is noted in the quote above. The key informant referred to the inherent superiority of males in the Chuukese society and described the perception that raising one’s voice to a male Chuukese was a sign of disrespect and considered rude behavior. Gender norms are part of Chuukese society. These norms are complex and relate directly to the incest taboo previously described. The female Chuukese key informants related how these cultural norms affect the behavior of women. When asked how the gender norms affect Chuukese men and women needing health care, and if there was a preference for male or female health care workers, the key informant explained that the gender issue can be problematic for females, but not necessarily for Chuukese males. Her comments also reflect the modesty rules governing Chuukese female behaviors.

I think that for the Chuukese men, it doesn’t really matter. Some of the men may not feel comfortable with a female health care worker. But it’s not as bad for the men as it is for the women. Because the men in Chuuk, they can shower together in the stream, naked, it’s no problem. But for us, even in a group with all women, we cannot be naked. For females, we consider the area down here as private [points to groin and legs] but not up here [pointing to breast area]. When we go to the stream to bathe, even if we are all women, we cannot just wear our underwear. It may not be a problem for the young girls, but for women my age, especially if there are older women such as our elders present, we cannot just wear our underwear because it is disrespectful. We should not show our private areas to others. We have to cover our lower body with clothes. It is worse for women. For the men, it is OK for them to show their bodies. Key informant (K6)

Another Chuukese female key informant described the gender issue as a problem only if the health care worker is a Chuukese male. According to the Chuukese key informants, receiving
care from a non-Chuukese male is acceptable to Chuukese migrants in Guam:

If it’s not a Chuukese male there is a difference. It’s funny; I’m going to explain this. The Chuukese men, from my experience, if they see your private parts, they’re going to announce it. You know, if they see your private area they’ll say this and that, you know. So it’s just that the Chuukese women don’t want to be embarrassed. They don’t want Chuukese men to see them. She may not want that person to see her or he’s going to go around and say, I saw this. But yes, if the doctor or worker is from a different nationality he’s fine. Key informant (K7)

In discussing barriers in the focus groups, none of the women identified receiving care from a male provider as a concern. Several women reported receiving care in the emergency room from a male physician but did not report gender as an issue. The barriers the women reported in the emergency room related specifically to communication problems or the long wait times previously described in this chapter. One woman stated, “I went to the hospital for my C-section to have my baby. I liked the doctor. He was very nice. I had no problems.” This statement reinforced the perception of the two Chuukese key informants that a male provider may be acceptable to Chuukese female patients if the provider is not a Chuukese male.

The Chuukese key informant gave a thorough description of the gender implications and the cultural issues surrounding these complex norms. Her final comments were distressing and were not reflected by other participants. Moral (1998) referred to the erosion of the power of Chuukese women because of the decline of the importance of the lineage. The change in family structure from extended family to nuclear family has increased the power of men, but caused a decrease in the power held by Chuukese women. Moral (1998) attributed an acceptance of domestic violence to this change. Although the comments from this one participant are different
from other respondents, the researcher felt that these comments speak powerfully of the perception of male superiority and the impact on the familial role of Chuukese women:

I went to Chuuk right after graduation. I already preregistered at the university. I went to Chuuk, and the only thing that was pending for me to have at the university was the physical. When I went back to Chuuk, they said you can have this even in Chuuk, as long as it’s a doctor; it’s signed by a doctor. So I went to the hospital and asked who can perform my physical exam. And they said doctor X [Chuukese male doctor]. I asked, “It cannot be a woman?” You know, at that time I was still a virgin. I said, “That guys going to see my private area? He’s not even my husband.” I said, “Forget it.” And I never came back. I said, “No, no he’s going to see my private areas.” Every time he sees me he’s going to laugh at me because he saw my private area. That’s our mentality because that’s what’s happening. That’s what the men do, because of the fact that they’re higher than us women. You know in Chuuk, they can rape us; they can do whatever they want. They can touch us. There’s no law that can protect us women. In Chuuk, no way, the men, that’s why they’re allowed to do anything. That’s why they can even have two wives. They’re dominant, and that’s why they step all over us. They can have you sexually and then they go out and announce it to their men friends. Key informant (K7)

During the discussion of stigma and marginalization, several key informants reported that Chuukese migrant women in Guam are becoming more assertive and will stand up for themselves and their children when faced with poor treatment. This is a positive aspect from the perspective of several key informants:

Yes, and you’re going to notice that because they’ve been picked on for so long, they’ve built up this defense. They’re not afraid anymore. They challenge you. They question
you. I think it is because when someone is picked on for so long, they’re going to fight back. And you’re going to see that the people that really stand up for themselves are the women. They’ll challenge you. They’re not afraid to speak up nowadays. Key informant (K3)

The responsibility for the health of the children may influence the increased assertive behavior on the part of Chuukese women. A key informant described the increased assertiveness as a positive change noted in the behavior of Chuukese women in Guam:

Now, they go into other programs in the clinic, the workers talk to them, or tell them what to do. But the way they talk to them is bad because they’re specifically from the islands, they’re from Chuuk. Now, the women would talk back, and they would argue back. The women are becoming more assertive. They know they’re right, and more so, they are standing up for the rights of their children that they’re representing. So it’s true, and I’ve seen it, and here in the clinic, in particular, because that’s where I observe them. But it happens not only in the clinic, but other areas and programs in the center. I can say that the Chuukese women are getting better in responding to those people who are putting them in that position. They respond to those people treating them badly. So, there’s some improvement. Key informant (K5)

Educational needs

A category that emerged during key informant interviews, but not in the focus group data, was educational needs. All key informants cited education as a barrier and a factor influencing the health-seeking behavior of Chuukese migrants in Guam. The limited education received by some Chuukese prior to moving to Guam was previously described during the discussion of the category of Communication issues. Subcategories of educational needs as described by key
informants included: health education and lack of knowledge of health, social, and educational systems in Guam. When asked to describe what kinds of problems Chuukese migrants have in obtaining health care and in maintaining good health, all key informants emphasized the lack of education and the need for education as a solution:

Again, they will not go to the clinics because of transportation problems (tapping hand on desk to emphasize). They will not seek assistance because they cannot communicate effectively in English. But again, if they are educated, they can communicate in this modern language of English. And I would say, the more they are educated (pausing) let’s go back again: Education means getting a job. Education means getting a job (repeated). Education means getting transportation. So, they are going to the hospital, but if they cannot get a job, or get educated, they would be stuck for a long time. So I would say the problem is lack of education. And the solution is (pausing for emphasis), help them to be educated. Key informant (K1)

The key informant went on to describe the impact of education on the health of the women and their families:

You know, my perspective is this: I have seen Chuukese women who are educated; not all of them. But I believe that it is more likely that the more educated they are, the better health they have. So education has so much to do with better health. So, the less educated they are, the more difficulty they would have. Key informant (K1)

All key informants cited a need for health education and a lack of knowledge in health related matters. Several voiced the perception that the Chuukese are not aware of when to seek health care services:
And then another thing is they don’t really know where to go, or the routine or when to come in. They don’t come in because they need a routine health maintenance appointment. They come in because it’s already too late; they already have a problem. One of the problems is they don’t remember to come in for their regular checkup. They don’t come in until they have a problem, and then they can’t deal with it. Key informant (K7)

Another key informant voiced the same perceptions that the Chuukese lack basic knowledge of when to seek health care services. The key informant explained that there is a need for education and continued reinforcement of teaching in order to improve health for this population:

But we also have others that we see—the communities that are not aware of what’s happening. They have no clue that someone is sick. Or that they are sick. They don’t know that a child is sick, or they just don’t understand it. It could be a mental issue. Maybe the child might just need some medication, but they don’t understand it. They think that maybe it will pass. There is a lot of ignorance due to not being educated. Key informant (K3)

Many informants gave specific examples of health-related knowledge deficit Chuukese migrants lack that affected their health and health-seeking behaviors. When asked to explain her perception that the Chuukese need education, a key informant described several specific areas of deficient knowledge:

Their diet for one. They are lacking in the knowledge of what makes up good health. They need health education about nutrition in a language that they understand. Education about diet because they eat whatever they can afford, if it’s something that’s not good for
them, or if it’s good for them, you know, they have to eat, so they eat. They buy because they can afford it, and that’s what’s available, so they eat it. They don’t really have a lot of knowledge as to what’s good for them. They don’t know what kind of food is good for them, what kind of food is not good for them. Sometimes they hear a lot of things, but it’s in English, so they don’t really understand. And sometimes they hear it from other patients. So, when you sit down and talk to them, you find out that they don’t understand what kind of food they need to eat in order to maintain their health and what kind of food they need to avoid if they have hypertension and diabetes, and other problems. But, not until you sit down with them do you find out what they know. So, a majority of the time, it’s lack of knowledge, education related to diet and chronic disease prevention, and health maintenance. Key informant (K5)

Another key informant described her observation that the Chuukese women are improving in terms of health-seeking behaviors, but still need more education and reinforcement of health teaching:

But I can say that ever since I’ve been working in Agency Y, I can say that women, Chuukese women, have improved. They have come a long way, and they have shown that they think about their health. They take it very seriously. You can see that they’re taking better care of themselves by coming to the clinic and coming for follow-up care. You know, you can tell that they’re taking their medicines, things like that. So there are some improvements, but they still need to be routinely oriented to the health care system. They need to be provided with health education again and again. Key informant (K5)

Lack of knowledge of health, social, and educational systems in Guam

All key informants described a lack of understanding of the health and social welfare
systems in Guam. One Chuukese key informant explained that in Chuuk, on the main island that is most westernized, the only hospital functions as a multi-purpose health center. Chuukese use the hospital for some non-acute care services such as for physical exams and for treatment during acute illnesses. One participant described going to the hospital to get a routine physical before going to college. Her lack of understanding about the Guam health care system had economic implications for both this Chuukese person who went to the hospital and for the hospital finances.

They don’t really understand the difference between the hospital and the clinics. They think that because they’ve been to the hospital before, they always go to the hospital for any type of care. Especially for newcomers in Guam, they think the hospital is where to go, like Chuuk hospital. We go there for anything pertaining to health care. The Chuukese don’t know about public health clinics. They need to make the Chuukese understand when to go to the hospital and when to go to the clinic. When the Chuukese go to the hospital, they don’t always get what they really need. And if the problem is minor, they charge them a lot. It is better to educate the Chuukese and tell them to come to public health centers rather than going to the hospital. They can come to the clinic for evaluation. They can refer them to the hospital from here if needed. Then they will pay less. That’s the problem now, some patients are sent to a collection agency for unpaid bills. They’re going after them. But you know it’s not that it’s because they want to go there, but they don’t understand the difference between public health centers and the hospital. Key informant (K6)

Several key informants recommended educating migrants before leaving Chuuk to assist in their transition to life in Guam. Specific topics mentioned were educating about what forms
and papers may be needed, such as birth certificates, immunization records, and health care records. This would ease their transition into the unfamiliar health, education, and social services system and assist providers when care is needed:

Why not educate patients from the Federated States of Micronesia before they leave and relocate here? Why can’t you educate them before they get here? There should be some sort of training, in-service or workshop, before they leave the island so they know what to do before they get here. Key informant (K4)

Several key informants gave similar suggestions to educate migrants prior to moving to Guam:

I think that it would be helpful for the Chuukese community also to educate their migrants before they came here, or to make some kind of requirement of a class, or something so that they better understand how the system works here. They come to me with family and the family tries to take care of them, but they have no concept of how the system works here. So, if you don’t have a family member here that speaks English well and knows the system well, they fall through the cracks and then they’re just trying to hide. You know they’ll come to school and their shots are not done. So I spend months following up making sure their shots are done. They’ve been here for a few years, but because they don’t know the system, they’ve just ignored the requirements and so they’re behind. Key informant (K2)

Maybe immigration should have a list of what they need before they move. They should give them a list at immigration because that is where they apply for a passport. Maybe give them a list when they apply for a passport so it will be easier before they move. This would help for those moving here to Guam, and to other places. There should be a list that tells them what to bring such as a birth certificate, because offices here, like the
Guam Housing and Urban Renewal Authority for housing, and to apply for food stamps, they need a birth certificate. And of course, at the clinic, they will need their health record including immunizations. For FSM citizens, you need a passport. Just give them a list, and they will obtain the required documents while the passport is being processed. And their life will be easier when they come. Key informant (K6)

One key informant emphasized the importance of educating the Chuukese before they migrate, and if not, then here in Guam: “And if you can’t do it back home in the island, before they get here. Then why not when they arrive and they’ll be required to take something.” Key informant (K4)

The category of educational needs emerged from the key informant data. The women did not raise these concerns and perhaps were not aware of their specific needs from an educational standpoint. This was evident in the lack of preventive care discussed previously. The Chuukese women did not understand that preventive care was important in maintaining health.

Political Influences Affecting Migrants

The Chuukese women did not specifically identify political factors that influenced health-seeking behaviors. Several key informants described political influences and concerns regarding the Chuukese migrants in Guam. Focus group participants voiced concerns that change needs to be made to improve the situation for the Chuukese migrants in Guam. Key informants and focus group participants voiced an urgent desire for change. One participant commented:

Yes, for all of these things we’ve been talking about like the poor treatment, the attitude, the problems we face trying to get medicine, and the problems with the lack of health insurance. Or the problems for those that have insurance such as Medicaid and MIP. So
by our meeting with you, would you be able to help improve or find solutions to these issues?

Another woman in the third group voiced similar sentiments, “Yes, this is very important that you know of the issues we face with the health care system in Guam and help the Chuukese population in seeking health care, insurance and in getting help from other health departments.”

Key informants also relayed this concern that change needs to occur in the near future. Several informants described a sense of being overwhelmed by the needs and number of Chuukese seeking care. All key informants emphasized the need to act now:

I think it has to be done ASAP. Because the longer we wait, it’s going to affect the economy. When people are healthy we don’t spend that much money, but when serious things happen, we spend a lot of money at the hospital. A simple boil can turn into something more serious down the road. Key informant (K3)

A key informant emphasized the need for employment opportunities and the idea that the Chuukese should have a plan before moving from Chuuk. The political atmosphere and the financial concerns surrounding the Compact of Free Association were also described by five of the seven key informants:

If we start out with the opinion that, well they should get a better job, so that way, the company that they’re working for can cover their health insurance. And another issue is that the system is just getting worse financially. You know, it’s the money. The money is getting less. I guess that’s where the Compact of Free Association comes in. They should have looked at it this way. Now that we can really move around in the States then let’s look at that. What if our people move out, and they make a living here in Guam, Hawaii, or in the States, then what can we do for them? Money has a lot to do with people’s
lives. I guess that our homeland can probably help us. Right now, Guam is complaining because they’re not receiving enough money from the Compact Impact. That’s one thing to do, if you want to be here, then, you have to have some kind of plan. You know, how you are going to survive and how you are going to take care of your health are important issues to think about and plan for. Key informant (K7)

And because a lot of them have just arrived on the island before they come and seek medical attention, they’re not eligible to receive MIP until after 6 months. The private entities don’t take self-pay so they end up here for dialysis. So they’re stuck, they can’t go back home to Chuuk. They have to find a way to relocate here or go to another island. But even Pohnpei has only two machines, but they’re very limited. In fact I have one Pohnpeian patient that was told there was no space for him to get dialysis in Pohnpei; you have to go off-island. So she ended up here, eventually she will be applying for MIP assistance. And if you look at the bigger picture, that’s why we’re suffering here at the hospital. Key informant (K4)

Several key informants raised the sentiment that migrants should not become dependent on the welfare system in Guam. Key informants referred to political factors and current challenges faced due to the migration, the economic impact and the Compact of Free Association:

I believe that the migrants, especially citizens from the Freely Associated States (FAS) should come here for education and employment opportunities. They should not come here just to live off the welfare system. Yes, if they come here for school and need the temporary assistance, then of course, they should receive assistance. But to come here and be dependent, that’s wrong. Key informant (K3)
I know some of these people, once they come from Chuuk; they think Guam is like Chuuk. But it is not. They have to pay rent, water, sewer, electricity, and things like that. I came from an island where there is no electricity, no inside plumbing. But they have to learn that it is different here. They cannot blame the government of Guam. Key informant (K1)

I think with what’s happening now, because of the economy, we are going to see that a lot of the migrants now, especially the Chuukese community; they might get a little skeptical about being interviewed. Because they might feel like everyone out there interviewing them is trying to send them home. Especially now with our own Counsel General saying the FSM citizens are breaking the law if they are receiving food stamps. This was just in the paper recently. I don’t know if it is really a problem, but it is scaring the migrants. So those in the FAS community are kind of skeptical about whoever is out there asking them questions. People are starting to be cautious. Key informant (K3)

The key informant voiced concern about a climate of fear he perceived existed in part due to inflammatory news reports such as the one referenced above about food stamps. According to the key informant, migrants who meet eligibility guidelines for food stamps and other welfare services could receive such services legally. The key informant voiced apprehension that this type of media attention may limit the willingness of Chuukese migrants to be open to outsiders such as this researcher and others attempting to improve health and social services for migrants in Guam. The key informant went on to describe concerns regarding migration:

It’s kind of sad because, you know, the U.S. opened up this migration opportunity and then it seems like now, from my own observation, they’re starting to monitor it. Maybe they are trying to control the number of people coming in, instead of finding other
solutions. Is the migration really the problem? When you compare it to other migrants, is the effect from the FAS citizens that much greater? I don’t know. That’s why I’m concerned. The Federal government opened this up, and now everyone is scared of these small nations of the FAS, when I think there are bigger, larger migrant problems. Key informant (K3)

One key informant had a positive perspective on the migration:

I would say the Guamanians have been the greatest hosts because there are so many challenges that the migrants have brought into Guam. But yet, you people have been very humble, you have been very patient to absorb it. And still want us to be a part of the community and reach out to help us. Key informant (K1)

**Suggestions for improving care to the Chuukese**

Many of the women had similar suggestions: provide translators, improve transportation, and provide outreach activities. Several women suggested outreach activities in the villages. “It would be helpful for them to make home visits for those who are unable to go out.”

Another woman in the same group made a similar recommendation when asked for suggestions to improve care to the Chuukese migrants in Guam: “To do home visits and outreach for those who have no transportation.” The same idea was given by another participant: “That could be one suggestion, to have outreach to remote or far communities and to have translators at the outreach events. It would help a lot for the Chuukese with transportation problems.”

One woman who had visited another state described a phone system used to allow Chuukese to hear instructions for certain forms in Chuukese. She also described the ease of access to translators in social and health care settings:
In the States, what the nurses do is just use the radio and press the button and call the patients. There is a guy that would help with translations when they question us. Even food stamps section in the States, they still have the translators come over and help with translations.

Several nurse key informants noted that the Chuukese are not resistant to learning but needed providers they can trust. The behavior of the provider was identified as a factor in whether the Chuukese women were receptive to health education:

They’re not unwilling to learn. They are willing to learn. It just takes the right kind of person so that they don’t feel that they are being talked down to, or that they are being treated badly because of who they are. And it’s one of the things that I pride myself in: that I have a good relationship with my Chuukese population. But I’ve been there since 1999 and so I’ve worked hard for them to know that hey, I’m on your side. It’s not you against me. That it’s you and me together, let’s try and get that done together. Key informant (K2)

Key informants recognized that the Chuukese needed help and sought out providers they trusted and who are familiar to them when help was needed. This provider was well known to the Chuukese community from her work in a previous setting. She described the role she played in assisting the women to receive the care needed. She also relayed the sense of feeling overwhelmed at the large numbers of people needing assistance:

When I introduce myself, I say that I’m from Micronesia, which will ease them a little bit. Even though I’m not from Chuuk, I’m from another island, but that may be the next best thing. And so oftentimes, although I’m still in the clinic, they still come, and say, “I need help.” I really don’t mind. But it goes to show they still don’t know where to go. So
at least I tell them where to go. This morning I had one patient that had cellulitis on the leg, so I said, “You need to go to the hospital.” They still drive here from home, and they still come to me and ask me for advice and direction. And I really don’t mind. It feels good to help, to be able to help more so with a population like the Chuukese that really need help. That’s the whole reason we are here, to direct and to help them. But sometimes it’s overwhelming. We had an outreach last Saturday, and we had over 200 clients. And I only went there to tell them about the outreach once. I spent half a day to go around and told them about it. I didn’t expect so many to attend. Key informant (K5)

Once you establish a relationship, they are comfortable. For the Chuukese, you have to be familiar with them in order to speak in a direct manner. And in return, they appreciate it. If you don’t know the person, you can’t talk to them in an assertive manner like that. But if you know the person you can be assertive and tell them, “You need to bring your child and come.” Key informant (K5)

One of the Chuukese key informants described the urgent needs of the population and lack of understanding of the system. “Yes, they come here, they feel very frustrated. That’s why I sometimes don’t have my lunch so I can help them. When they come, I say, no insurance, I say, here we cannot help you without insurance. So I refer them to the social worker.” Key informant (K6)

Another key informant also suggested outreach programs and the need to increase cultural competence of health care providers. The informant had recently attended a cultural competence training session and provided the researcher with an educational handout listing several cultural and ethnic groups in Guam and key points in working with clients in the health care setting. The handout listed all ethnic groups from the Federated States of Micronesia in one
category indicating that the different cultural groups shared the same beliefs. The key informant voiced concern that not all Micronesians can be placed in the same category in terms of specific health beliefs and cultural issues:

I think more of those outreach programs are needed because we can only do so much here in the hospital. We’re limited. I think cultural competence training for the staff helps. The staff comes in thinking all Micronesians like the Chuukese are the same, and you can’t say that Pohnpeians are the same as Chuukese. But yes, I think cultural competency is needed everywhere. Key informant (K4)

The category of educational needs described earlier related to some of the suggestions for how to improve care to the Chuukese migrants. Education needs to be done, keeping in mind the cultural gender norms when planning educational sessions. Discussions or teaching about sexually based topics cannot be done in a forum with both genders present. This relates to the incest taboo described earlier in the discussion of the Chuukese culture. The status of women is also reflected in the discussion of sexual issues and health teaching:

I think the Chuukese need education and increased awareness. They can do teaching in the churches. Churches draw the biggest crowd. They can work with their pastors or deacons and ask permission to have time to educate them. Depending on what you are educating them about, you have to divide up the men and the women. I think the churches will be the most effective setting. Key informant (K3)

It’s a biggie if you’re going to put a male and female together and talk about sexual topics or issues. It’s against our custom. It’s not just a custom: it’s disgusting because we’re not supposed to talk about those kinds of topics with females and males together. If I know your problems then I can get into your pants. So if you tell me your sexual
problems, that means you like me and you have feelings for me. The males are more dominant. So we’re afraid to expose ourselves to them because they’ll take advantage of us. Key informant (K7)

Education as a partial solution came up repeatedly with key informants. Barriers such as transportation also need to be taken into consideration when planning health education events for those in the migrant population who lack adequate transportation. Key informants emphasized the need for outreach and community-based education:

I would say, go back to education. That has been to me, the key. The more you reach out to them to educate them, the more you are going to help them. It’s difficult for them to search for health education and services because of transportation. You’ve got to take the services out to where it is most needed—in the community. You need to provide community-based care. You cannot expect them to come and look for the services because it is not easy. Key informant (K1)

Another key informant eloquently offered this solution to barriers affecting health-seeking and health maintenance behaviors for Chuukese migrants in Guam:

So, if we’re going to solve the problem for the long term, we have got to help people, not only to be healthy, but they must be educated to become productive, contributing members of our society. So Guam, we’re building on it. We can build a better future for our society. Key informant (K1)

Summary

Focus group participants shared their perceptions and feelings about the barriers they faced in seeking health care. Major barriers identified were financial issues, difficulty in obtaining care due to long wait times, transportation problems, and struggles with both language
and cultural nuances of communication. Women in all groups identified difficulty communicating with health and social service providers and a lack of translators, giving examples of miscommunication. The women perceived that they received poor treatment because they are Chuukese migrants, and their accounts validated the perception of marginalization. There was a strong sense that Chuukese migrant women were treated differently. A mistrust of the health care and social services systems was evident. The language and cultural barriers that exist contributed to mistrust and marginalization of this vulnerable population.

Several social and cultural factors influenced their health-seeking behaviors. The use of traditional Chuukese medicines affected when Chuukese sought help. The use of Chuukese medicine may be related to the lack of financial resources to seek help, or a lack of knowledge of health and when it is appropriate to seek care. The women did not embrace the concept of preventive care. Both issues, the use of Chuukese medicine and the lack of preventive care, were linked to the health education needs of migrants. Cultural factors such as the status of women, gender norms, and concerns of confidentiality when working with a Chuukese translator affected health-seeking and health maintenance behaviors. The issues of women’s roles and gender norms were complex and extended beyond the arena of health-seeking behaviors. These cultural norms were strong and deeply affected the lives of these women.

Women and key informants voiced a strong desire to improve the situation for the Chuukese migrants and gave suggestions for improving care. The key informants overwhelmingly related educational needs as a significant influence on the health-seeking and health maintenance behaviors of the Chuukese migrant women. Key informants perceived that improved education would lead to improved health and social outcomes. The participants
articulated a clear mandate for change and emphasized the urgent need to improve health care for the Chuukese migrant women in Guam.
Chapter 5

This study examined perceived barriers to health care among Chuukese migrant women in Guam and factors that influenced health-seeking behaviors. Through focus groups and key informant interviews, the researcher’s goal was to obtain recommendations for interventions that may reduce those perceived barriers to health care. Analysis of interview data revealed themes that included three Themes: (a) barriers to seeking and maintaining health; (b) social and cultural factors influence health-seeking behaviors; and (c) political influences affecting migrants. A discussion of the findings was included in this chapter. The researcher provided recommendations and implications for nursing practice, education, and future research. The limitations of this study were described and a summary of the study concluded this chapter.

Discussion of Theme One: Barriers to Seeking and Maintaining Health

There is a dearth of literature on the barriers to health-seeking and health maintaining behaviors among Micronesian Islander populations. The barriers identified by the Chuukese women included lack of health care insurance, inability to meet insurance co-payments if insured, lack of transportation, long wait times when seeking health care, and communication barriers. The communication barriers reported by the Chuukese women were inability to communicate with health care providers and mistrust resulting from communication barriers. Key informants identified similar barriers to health-seeking behaviors that included the lack of health care insurance, lack of employment, transportation problems, communication issues and a need for translators. The literature on Micronesian populations and the identified barriers to health-seeking behaviors supported several of the present study’s findings related to the health care barriers (Aitaoto et al., 2009; Shoultz et al., 2007; Williams & Hampton, 2005). The identification of transportation problems, economic difficulties, low income, and communication
issues as barriers to health-seeking was consistent with findings from Aitaoto, et al. (2009), who found these same barriers to be major impediments to health-seeking behaviors for Chuukese migrants in Hawaii.

A study of intimate partner violence (IPV) included Chuukese migrant women in Hawaii and cited poverty, lack of employment, and low incomes as factors that influenced health-seeking behaviors of Chuukese women (Shoultz et al., 2007). In a study of Marshallese migrants living in the United States, barriers reported included lack of trust, language and communication problems, financial barriers, lack of knowledge regarding available resources, systemic problems such as issues with immigrant status, and the problems associated with the complex American health care system (Williams & Hampton, 2005). The Chuukese women in this study reported similar barriers encountered when seeking health and social services in Guam. The findings gleaned from the previous studies of Micronesian Islanders who migrate to the United States can add to the understanding of common issues faced by FAS migrants.

Difficulty navigating through the U.S. health care system was a finding in both this researcher’s study of Chuukese women in Guam and the study of Marshallese by Williams and Hampton (2005). The identification, however, of long wait times when seeking health care services was a finding unique to this study and was not found in the literature review. The Chuukese women participants described frustration with the excessive wait times at the hospital and clinics, and several women indicated that these resulted in part from the lack of caring of the health care workers. There was a sense of mistrust that emerged when women discussed the long wait times when seeking health care, and the difficulties faced when trying to communicate with health care and social service workers. Mistrust was identified in the study of the Marshallese people; however, their mistrust was related to their previous experience with the American
military in the Republic of the Marshall Islands and their fear of the western health care system (Williams & Hampton, 2005). The trust issue described by the Marshallese was not related to communication difficulties as described in this study of Chuukese migrant women in Guam.

**Communication Issues**

Problems with communication emerged as an important subcategory of barriers to obtaining health care and was identified as a barrier by all Chuukese women participants and key informants. Subcategories identified were the inability to communicate with health care providers and mistrust resulting from communication barriers. The literature supported the finding of the inability to communicate or understand the language as barriers to health-seeking behaviors (Aitaoto et al., 2009; Choi, 2008; Williams & Hampton, 2005). Consistent with this study’s findings, Williams and Hampton (2005) cited language and communication difficulties as barriers to health-seeking behaviors. Marshallese migrants had difficulty comprehending English and could not understand the medical terminology and anatomy words used by health care providers. Some of the words for anatomical parts of the body do not translate easily into Marshallese. The Marshallese experienced frustration in communicating with providers and were less likely to seek health care if a translator was not available (Williams & Hampton, 2005).

Whereas, the Chuukese in this study preferred that the translator not be known to them.

The Marshallese experience with communication problems supported the findings of this study of Chuukese women in Guam. The Chuukese women described frustration over the inability to communicate with health care providers. Participants in all groups described situations involving difficulty communicating in English with health and social services workers. Specific examples illustrated the challenges faced because of the language and communication barriers. A lack of appropriate translators in health care facilities was cited as a problem by the
women and by all of the key informants. The practice of using family members as translators was not adequate to meet the communication needs of Chuukese seeking health care. Nurses can improve health care for the Chuukese by being aware of the communication barriers and the resultant mistrust that can occur due to miscommunication. The recommendation to have appropriate Chuukese translators to assist when needed in health care facilities was made by key informants and many of the women in the focus groups. Several women voiced concern that the lack of translators prevented some Chuukese migrants from seeking health care services.

When discussing the Chuukese and language issues, key informants described behaviors of the Chuukese clients who respond “yes” to questioning and who do not ask questions of health care providers. Key informants speculated that perhaps these behaviors were an act of respect for the provider rather than an indication of understanding by the Chuukese migrants of the English language or the instructions provided. A passive approach by Chuukese women is congruent with previously described cultural norms governing female behaviors. These norms include the inherent view of male superiority, the limitations on women to speak publicly, and the perception of women as dependent (Moral, 1998). There is no published literature describing the behaviors of the Chuukese in responding affirmatively to questions by health care providers. This is an area that needs further nursing research.

The study by Williams and Hampton (2005) also cited reluctance on the part of Marshallese to ask questions out of respect for the health care provider, who was deemed an authority figure. Marshallese clients were described as having a stoic “non-communicating” manner. Some providers may interpret this silence as agreement. According to the study findings, the behavior and lack of response may indicate a negative answer (2005). The behavior
described of the Marshallese did not mirror the behavior described by key informants in this study of Chuukese migrant women in Guam.

The difference in behaviors among Marshallese clients and Chuukese clients highlights the need for further research. It is important that the differences among Micronesian Islander groups be explored in order to provide culturally appropriate care. Many health care workers are not knowledgeable about the various Micronesian cultures and are unaware of cultural differences that exist among the peoples of the Freely Associated States. The perception that all Micronesian Islanders share the same cultural practices related to health and health-seeking is not accurate. Several studies, however, that described findings for various ethnic groups such as Marshallese and Chuukese included them together in one category labeled “Micronesian” (Aitaoto et al., 2009; Pobutsky et al., 2009). This study of Chuukese migrant women revealed findings that were not present in the current literature on other Micronesian Islander subgroups. While similarities do exist, differences among the cultural groups are evident and an increased understanding of these similarities and differences may lead to care that is culturally sensitive. The need for research on specific Micronesian subgroups will be explored further in the discussion on future research needs.

In other studies among Chuukese or other Micronesian ethnic groups in the United States, language was not consistently cited as a barrier to health-seeking (Aitaoto et al., 2009, Wong & Kawamoto, 2010). In a study by Wong and Kawamoto (2010), barriers to cervical cancer screening among Chuukese women in Hawaii were explored. Researchers specifically reported that language barriers and financial concerns were not identified as barriers to screening. The participants were described as comfortable with English since they were long-time residents in the United States. The average length of time in the United States was 8.6 years. Only one of the
participants was uninsured and the researcher cited these characteristics as possible reasons that language and financial concerns were not identified as barriers.

Participants in a study of barriers to breast and cervical cancer screening perceived by Marshallese, Filipina, Hawaiian, and Chuukese women did not identify language as a barrier. Key informants identified, however, the inability to speak and understand English as a major barrier to screening. The researchers did not indicate reasons that the women may not have cited language as a barrier (Aitaoto et al., 2009). This researcher’s findings of language as a barrier for Chuukese migrant women in Guam differed from the findings of these two studies. Although participants in this researcher’s study lived in Guam longer than the migrants in the Hawaii study, the language barrier was reported in all focus groups. The average number of years living in Guam was 10.14 years as compared to the average in the Hawaii study of 8.6 years; participants in all groups and all key informants in Guam reported language and financial issues as barriers.

**Social and Cultural Factors Influence Health-seeking**

Women and key informants identified social and cultural influences on health-seeking behaviors. The data revealed that many factors beyond access and affordability issues affected Chuukese women’s health-seeking behaviors. Cultural factors included the use of Chuukese medicine, the lack of preventive health care, concerns about confidentiality when using Chuukese translators or Chuukese staff members, and the role of Chuukese women. Social factors influencing health-seeking behaviors included feelings of mistreatment by members of the health and social services system, and educational needs.

**Use of Traditional Chuukese Medicine**

Chuukese women varied in their accounts of the use of Chuukese medicine. Most
identified the use of medicines to treat childhood fevers, runny noses, cold or flu-like symptoms. These women reported seeking Western medical care if the Chuukese remedy was not effective. Other women reported using Chuukese medicines after first seeking Western medical care, but finding it to be ineffective. Key informants had the perception that Chuukese medicine practices were used because of an inability to seek Western health care when financial limitations and lack of insurance existed. Key informants cited the lack of knowledge of when to seek health care as a factor in the use of Chuukese medicine. Several key informants recommended specific education of migrants to increase knowledge of when to seek health care for themselves, their children and other family members. Key informants voiced concern that the lack of knowledge about when to seek health care, coupled with a lack of insurance or access to health care, led women to try Chuukese remedies and delay health-seeking even in cases, such as fractures, when health care should be sought immediately.

The use of traditional Chuukese medicine was not described in the literature. None of the studies previously described in the literature review of Micronesians or FAS populations identified the use of cultural health practices as a barrier to health-seeking. One study specifically addressed the use of Western rather than Marshallese cultural medicines or practices by Marshallese migrants (Choi, 2008). One of the themes identified in the study of health-seeking behavior was that Marshallese migrants rely on the allopathic Western health care system rather than cultural health care practices or treatments. Marshallese migrants who move to Hawaii in search of health treatment not available in the Marshall Islands are more likely to believe in the efficacy of Western medical treatments (Choi, 2008). The reliance on the Western health care system is reflective of the findings in this study. The Chuukese migrant women in this study described both a reliance on Western medical care as well as some use of cultural
medicines for specific illnesses. Chuukese migrant women in Guam did not exclusively rely on Chuukese medicines or health practices. Women reported differing utilization of Chuukese medicines by migrants in Guam. They reported that some migrants will use Chuukese medicines if Western health care was not perceived to be effective in treating an ailment, while others will use Chuukese medicines prior to seeking Western health care services. If the Chuukese remedy is perceived to be effective, then Western health care is not needed. Two key informants reported a perception that Chuukese traditional medicines were used because of lack of insurance rather than relating it to a reliance on Chuukese cultural practices versus Western medical care. This finding was not supported in the literature and further examination of the use of Chuukese medicines is warranted.

**Lack of Preventive Care**

Chuukese women described patterns of health-seeking that clearly did not include preventive care beyond prenatal care and immunizations for children. Even women with identified health conditions reported not seeking health care on a regular basis. It was clear that the concept of preventive health care was not a priority for these women. The focus on prenatal care and immunizations reflected the women’s roles as caretakers and the individuals responsible for the health needs of their children. The literature reviewed supported the findings of this study (Choi, 2008; Williams & Hampton, 2005; Wong & Kawamoto, 2010).

The Chuukese women and the key informants in this study reported knowledge of and compliance with childhood immunizations. The focus group data indicated, however, that for the Chuukese migrant women there was a lack of preventive health care such as screening, chronic disease prevention and management as well as a lack of seeking care in women’s health services beyond prenatal care. Key informants working with Chuukese women identified a lack of health-
seeking behaviors in the areas of family planning, screening activities such as Pap smears, and routine physical exams. The literature on Chuukese health-seeking behaviors was limited but the overall information available was consistent with this study. Wong and Kawamoto (2010) identified a lack of knowledge of women’s health services including screening and preventive care in a study of Chuukese women in Hawaii and barriers to seeking cervical cancer screening services. The researcher noted the Chuukese women had a lack of interest in going for a check-up, and the women were unaware about the need to receive screening services. The researchers recommended education on the importance of screening and highlighted the need for a cultural emphasis on gender-specific ways to deliver services and educate this population in Hawaii (Wong & Kawamoto, 2010). The findings in the literature regarding education and the need to address cultural concerns were consistent with the recommendations of Chuukese women and key informants in this study.

Choi (2008) identified the theme of “Present crisis-oriented health care” as a major influence on Marshallese migrant health-seeking behavior. Key informants described preventive care such as screening and regular check-ups as a concept foreign to the Marshallese. Consistent with the findings of this study of Chuukese women in Guam, the Marshallese women were unaware of the need for screening such as mammograms and Pap smears. Marshallese women also reported that they had not received information and encouragement from their physician to seek preventive care even if they had been seeing a physician for other medical conditions (Choi, 2008). Immunizations are an area of preventive care not influenced by a crisis orientation. Migrants reported high compliance with immunizations; this may be due in large part to the successful immunization programs present in the Marshall Islands. Requirements in the state of Hawaii for immunizations for school and employment also bolstered the knowledge and
compliance of the Marshallese. In Choi’s (2008) study, Marshallese women had a low level of awareness and lack of belief in the need for preventive care and women’s health services. This lack of awareness is similar to the finding of this study of Chuukese migrant women.

Confidentiality Concerns

Focus group participants expressed the desire to have Chuukese translators, but were also clear that they had reservations about speaking openly if Chuukese translators are used. Chuukese women voiced concerns that Chuukese translators may not maintain confidentiality. They clearly expressed concern that their health and social problems would be shared with other Chuukese. The issue of trust emerged when women were asked specifically about use of Chuukese to translate. They immediately responded that they would like Chuukese translators to assist; however, would speak openly only if the translator was someone they trusted. Several women gave examples of trusted women, such as women from their church or older Chuukese women. Chuukese key informants explained that the concept of confidentiality in the Western health system is foreign to the Chuukese migrants in Guam. Therefore, when Chuukese come to Guam, Chuukese translators must clearly explain that their job responsibilities included the maintenance of confidentiality and that as a translator, they would not disclose private information. Chuukese women would not openly discuss private information if they did not trust the translator. This finding is unique to this study and was not noted in the literature of health-seeking behaviors and Pacific Islanders. Rather, the literature identified the need for translators (Choi, 2008; Pobutsky et al., 2009; Williams & Hampton, 2005) without mention of the confidentiality concerns identified in this research with Chuukese women in Guam.

Researchers in one study recommended caution when using health care workers from the same ethnic group when working with women victims of intimate partner violence (IPV), but the
concern of confidentiality was not expressed by study participants themselves (Magnussen et al., 2011). In a study of IPV and help seeking among Chuukese, Samoan, Filipina, and Native Hawaiian women in Hawaii, participants recommended that members of their ethnic group who are staff at the health facilities may be best suited to assist them if they were also victims of IPV. Researchers cautioned, however, that hiring staff from within a small group or specific neighborhood may pose confidentiality issues and lead to barriers preventing the women to openly disclose information. Women from all four ethnic groups described a strong sense of belonging to a collective and the importance of the cultural group. Women were reluctant to report IPV for fear others would find out and the family’s reputation would be negatively affected (Magnussen et al., 2011). The caution regarding hiring staff from the same ethnic group within small communities supported the researcher’s experience while conducting the study. During recruitment of women focus group participants, the identity of the female Chuukese translator appeared to be of importance to the women. Before they consented to participate in the study, participants questioned the interpreter about her familial ties and which specific Chuukese island she came from. The women participants did not know the translator for this study. The translator was not closely or distantly related to the women and not a member within their local communities in Guam. This finding regarding confidentiality concerns is unique and should be shared with the health care community working with this migrant population.

**Feelings of Mistreatment**

Chuukese women described their perception that health and social service workers in Guam mistreated them. They indicated fear as a barrier to health-seeking behaviors and used the words “scared” and “afraid” to describe how some Chuukese felt about health care workers. This fear and feeling of mistreatment prevented some Chuukese women from seeking help. Key
informants described situations of mistreatment or marginalization of Chuukese clients in health care and social welfare settings. The findings of marginalization and perceptions of mistreatment were not widely reflected in the literature. Two of the articles involving Pacific Islander ethnic groups identified poor treatment and feelings of prejudice and discrimination perceived by study participants (Pobutsky et al., 2009; Williams & Hampton, 2005).

Williams and Hampton (2005) reported the experience of prejudice and maltreatment in U.S. health facilities as a barrier to health-seeking behaviors. This is consistent with the study findings of mistreatment experienced by Chuukese migrant women in Guam. It is important to note that the historical experience of the Marshallese differs from the Chuukese and the lack of trust reported in the literature is not similar to the experience of the Chuukese in Guam. The previous experience of the Marshallese with the United States and destruction of their homeland by the U.S. military has left feelings of distrust. This lack of trust was coupled with a fear of the U.S. health care system (Williams & Hampton, 2005). The Chuukese women in Guam reported mistrust resulting from communication barriers. The theme of mistrust of the health care system resulted from their perceptions of poor treatment rather than fear. The expressions of fear described by the Chuukese women were directly related to the treatment by health care workers. Previous negative experiences created a sense of fear. The awareness of the perceptions of migrants and the effect it may have on their health-seeking behaviors can assist nurses and other health care workers caring for this population. Recognition that there is an element of fear and mistrust among Chuukese may help to promote more sensitive nursing care.

The findings of this study are similar to studies of Micronesian migrants in Hawaii that identified social and cultural issues affecting health and education. Participants reported feelings of poor treatment, discrimination, and prejudice faced by migrants in Hawaii when seeking help
from health, education, and public welfare agencies. Researchers referred to media reports in Hawaii of employment and housing discrimination which had implications for the health and social status of migrants (Pobutsky et al., 2009). It is important for nurses and other health care workers interacting with Chuukese and other Micronesian migrants in Guam to be aware of the perceptions of poor treatment. Several key informants described a sense of being overwhelmed by the numbers of Chuukese needing health care and inferred that perhaps the large numbers needing assistance contributed to the poor treatment by some health and social service workers. The phenomenon of marginalization was evident in the key informant data. Key informants reported they observed incidents of poor treatment of Chuukese migrants and identified stigma associated with this marginalized population. All key informants voiced the need for change and improvements in the health care for Chuukese migrants in Guam.

Role of Chuukese Women and Cultural Influences

Health-seeking behaviors of Chuukese women were influenced by cultural factors and gender norms prescribing behaviors and roles of women. Male superiority and female subservience were important influences in the lives of these women. Complex avoidance behaviors are culturally mandated by the incest taboo described in Chapter 2. Female Chuukese key informants expressed how gender norms affected Chuukese men and women needing health care. Informants described gender issues as more significant for women and less problematic for males. The key informants were clear in their unwillingness to receive health care services from a Chuukese male provider. The reports from Chuukese key informants that female Chuukese have objections to receiving care from a male Chuukese provider were not supported in the literature. It is significant, however, to note that key informants explained that receiving care from a non-Chuukese male health care provider is acceptable to most migrants in Guam. They
expressed an understanding that many health care providers are male, and that there is an acceptance of treatment by non-Chuukese males in the western health care system. There appears to be greater concern related to being cared for by a Chuukese provider who may be related to, or have knowledge of the participant’s family, rather than an issue of gender. None of the women in the focus groups identified care from a non-Chuukese male provider as a concern or barrier.

The cultural norm of modesty affected Chuukese women’s health-seeking behaviors. The issues of modesty and the subject of sex as taboo were reflected in studies of Micronesian migrants (Williams & Hampton, 2005; Wong & Kawamoto, 2010). Modesty was a major barrier in clinic settings, especially when exposure of women’s private areas was needed for a physical examination (Williams & Hampton, 2005; Wong & Kawamoto, 2010). Sex is considered a taboo subject and not spoken of in public settings. This taboo limits communication in areas of intimacy and sexuality and can affect assessment of possible problems. Recommendations to have same gender health care providers were made as a means of minimizing embarrassment when discussing issues that may be considered personal and difficult for Marshallese to disclose (Williams & Hampton, 2005). The findings in the literature reflected those of this study of Chuukese migrants. It is important for nurses to be aware of and assess the strong incest taboo and the gender norms created when they are working with Chuukese migrants. Chuukese female key informants described modesty rules governing female dress and behaviors. The example given in Chapter Four by a key informant who explained to a Chuukese woman and her husband what a Pap smear was illustrated the importance of providing explanations and assessing for understanding. The female client and her husband walked out after the procedure was described by the key informant and refused to have the Pap smear. This example demonstrated the communication barriers as well as the strong issues surrounding modesty and sexuality.
Understanding the cultural norms that influence health-seeking behaviors can assist nurses working with Chuukese migrants to provide care that is more culturally competent.

The key informants in this study of Chuukese migrant women advocated for education regarding issues of a sexual nature to be given by same gender educators and with groups separating the genders. The taboo against discussing sexual matters in mixed-gender groups was clearly articulated by several key informants. In planning education and outreach to the Chuukese migrants in Guam, knowledge of this taboo is critical and needs to be taken into consideration. Consistent with findings of this study, Wong and Kawamoto (2008) provided recommendations for increased education for health screening along with a detailed explanation of the importance of Pap smears. Education was recommended to take place through Chuukese women’s group meetings. The need to educate Chuukese men was also stressed. Education for Chuukese men should be provided by another male, with no women present. The women expressed the importance of both the husband and wife reaching consensus in order for the woman to agree to have a Pap smear (Wong & Kawamoto, 2008). The recommendation for education of both the husband and the wife is applicable to the previous situation that was described by a key informant. Perhaps if education regarding the Pap smear was given to both the patient and her husband prior to scheduling the appointment, the incident could have been avoided.

The findings of this study regarding the role of Chuukese women and cultural expectations that influenced health-seeking behaviors were supported in the literature (Magnussen et al., 2011; Shoultz et al., 2007). The cultural role of Chuukese women as peacekeepers of the family was identified as a barrier to help-seeking in a study of IPV and Pacific Island women in Hawaii (Shoultz et al., 2007). The cultural roles and expectations of
Chuukese women were identified as risk factors when faced with IPV. The migration away from Chuuk to Hawaii also contributed to risk because of the loss of traditional support systems for women. The traditional support systems consisted of their sisters, mothers, and other close female relatives who provided support on a daily basis. In Chuuk, women have social and family supports such as the extended family and other cultural ties but this changed when they migrated. The family structure changed from extended to nuclear, and the support from their sisters, mothers, and other extended family was not present as protective factors when women migrated. The changes in family structure and support systems placed them at risk when faced with issues such as IPV (Shoultz et al., 2007). Further examination of the traditional role of Chuukese women and how it affects health-seeking behaviors is needed.

Several key informants recommended providing education through outreach efforts when discussing recommendations for improving care to the Chuukese migrants in Guam. They described the importance of reaching the Chuukese migrants through their churches or in their communities. Key informants related the importance of collaborating with the Chief of the Chuukese community or the church pastor. Two of the key informants emphasized the importance of following cultural norms when planning education in group settings. Community outreach staff working with Marshallese and Chuukese women in Hawaii described difficulties resulting from the social circles of Micronesian women that limit the flow of information into the group. The Micronesians were described as having a group orientation that differs from the Western individualistic focus. The community workers identified difficulties with cultural norms and protocols that must be followed in order to educate the women about health issues, in particular, issues regarding sexuality such as the need for cervical and breast cancer screening (Aitaoto et al., 2009).
In conducting the focus groups for this study of Chuukese migrant women in Guam, the researcher was aware that in order to gain acceptance and participation in the study, permission needed to be obtained from the Chief of the Chuukese enclave in which one of the focus groups was held. All of the women asked if the researcher had permission from the Chief before they would consent to participate in the focus group. The importance of understanding and working within the cultural norm needs to be shared with the nursing community. Those who plan and provide community education and outreach to Chuukese migrants in Guam will benefit from the knowledge gained from this study.

**Educational Needs**

All key informants cited lack of education as a barrier and factor influencing the health status and health-seeking behaviors of Chuukese migrants in Guam. Informants described educational needs including health education and the need for an increased understanding of the health, social, and educational systems in Guam. Education was cited by all key informants as a solution to the problem of Chuukese migrants in obtaining health care and in maintaining their health. Education and the continued reinforcement of health teaching were recommended. Key informants identified many areas of deficient knowledge including diet, exercise, need for preventive care (beyond immunizations and prenatal care), and specific teaching of disease conditions such as hypertension and diabetes. The literature supported these findings of the need for increased understanding of the health care system and specific education needs related to health conditions and preventive care (Aitaoto et al., 2009; Choi, 2008; Shoultz et al., 2007; Williams & Hampton, 2005; Wong & Kawamoto, 2010).

The finding of this study that education is a significant need for the migrant population is supported in studies with Chuukese and other migrant populations in the United States. Aitaoto
et al. (2009) identified a limited understanding of breast and cervical cancer as a major barrier to screening of Pacific Islander women. All participants reported they had heard of breast and cervical cancer but 94% felt they did not know enough about cancer, the need for screening, and how to obtain screening services for cervical and breast cancer (Aitaoto et al., 2009). Similar findings regarding education were noted in a study of cervical cancer prevention and screening among Chuukese women in Hawaii. The lack of knowledge regarding cervical cancer and the need for preventive services were cited as major barriers to health-seeking behaviors of Chuukese women (Wong & Kawamoto, 2010). Marshallese women in Hawaii also had limited knowledge regarding women’s health services, and this affected health-seeking behaviors (Choi, 2008). A limited education was identified as one of many socio-economic issues faced by Chuukese women migrants in Hawaii. Limited education was also a factor affecting a woman’s ability to consider alternatives when faced with IPV (Shoultz et al., 2007).

Lack of knowledge of health and social welfare systems in Guam was identified as a barrier to health-seeking for the Chuukese migrant women in Guam. Key informants reported a lack of understanding of services available at the public health centers and an inappropriate use of the hospital, resulting in financial burdens for the Chuukese patients and the hospital. Some Chuukese sought non-emergent care at the hospital emergency room because of lack of knowledge of the services offered by public health. Many Chuukese migrated to Guam without bringing important documents such as birth certificates, immunization and other health records. The finding related to a lack of understanding of the health care system is supported in the literature. Williams and Hampton (2005) reported that a systemic barrier when working with Marshallese in Arkansas was the lack of understanding of their legal status in the United States, insurance eligibility requirements, and the complex U.S. health care system. The lack of
understanding was a barrier to health-seeking behaviors affecting Marshallese in the United States and reflected the finding of barriers as identified by key informants in this study of Chuukese migrant women in Guam.

**Political Influences Affecting Migrants**

Political forces were not cited by Chuukese women participants as a variable that influenced their health-seeking behaviors. Key informants, however, voiced concerns and described political influences that affected migrants in Guam. Key informants and the Chuukese women relayed a concern that changes needed to be made to improve care for Chuukese in Guam. All key informants emphasized the importance of making changes to improve the situation, and women in each of the focus groups voiced hope that through their suggestions, care for this migrant population could improve. Several informants stated concern that the continued financial impact on the government would adversely affect the whole island, rather than affecting only the Compact migrants. The literature on the Compact migrants from the FAS did not describe political factors as a barrier to health-seeking behaviors. The findings in the literature reported the financial impact of the Micronesian migration to Hawaii in the areas of health, education, and social services (Pobutsky et al., 2009). Challenges to the U.S. health system in meeting the needs of the migrant populations were described in the literature (Pobutsky et al., 2005, Williams & Hampton, 2005). The literature did support the finding that changes need to be made in order to improve care to the migrant populations (Choi, 2008; Pobutsky et al., 2005; Williams & Hampton, 2005). Barriers faced by the migrant populations contributed to negative health outcomes and exacerbated pre-existing health conditions. The researchers advocated for action to be taken to improve health-seeking behaviors, reduce
barriers, and positively influence the health status of Micronesian migrants (Choi, 2008; Williams & Hampton, 2005).

**Recommendations from Participants**

Recommendations to improve care to the migrant population included providing translators, establishing outreach activities to provide health care services in the villages, and improving the transportation system. The literature supported the recommendations for translators and health care workers from the same ethnic background (Aitaoto et al., 2009; Choi, 2008; Williams & Hampton, 2005; Wong & Kawamoto, 2010).

All key informants in this study of Chuukese migrant women recommended a variety of education strategies to improve the health of this vulnerable population in Guam. The nurse key informants advocated for consistent and repeated education about basic healthcare issues such as the need for preventive care, nutrition and diet teaching, and basic information on chronic illnesses such as diabetes and hypertension. Instruction regarding when it was appropriate to seek health care was mentioned in the discussion about the use of local Chuukese medicine. One key informant recommended teaching to encourage parents to bring children in for evaluation of serious injuries such as fractures, rather than attempting healing through Chuukese medicines and cultural practices.

Women reported knowledge of the need for prenatal care and immunizations for their children; however, they did not seek health care for their other health care needs. All key informants cited this finding of the need for education. The women participants did not identify education as a barrier and were not aware of their specific educational needs. It was evident that the Chuukese women did not understand the importance of preventive care in maintaining health. There was a lack of understanding of prevention of chronic diseases, cancer screening, and
women’s health services other than prenatal care. A key informant working with women’s health noted that other than prenatal care and immunizations, women do not seek routine health care such as Pap smears, family planning or other health screenings. Even women who identified themselves as having health problems, also stated they did not seek health care on a routine basis. The lack of knowledge of prevention and screening can be addressed through ongoing educational campaigns targeting the Chuukese population. Key informants recommended education in many areas of health and health care including nutrition, exercise, prevention of chronic illness, management of disease, knowledge of when to seek health care, and screening for illness such as diabetes, hypertension, breast and cervical cancer.

Several key informants recommended cultural sensitivity and communication from providers who are sensitive to Chuukese cultural norms. For example, education regarding issues of a sexual nature should be conducted in settings with the genders separated, as sex is a taboo subject and discussions with both genders present are not culturally acceptable. Key informants recommended education and outreach through Chuukese church groups. This was consistent with findings from the literature (Aitaoto et al., 2009; Choi, 2008; Williams & Hampton, 2005; Wong & Kawamoto, 2010). The recommendations in the literature regarding interventions and education of Micronesian migrants supported the findings of this study of Chuukese migrant women in Guam.

Several studies provided recommendations for culturally sensitive, gender-specific approaches for education and screening to decrease barriers to health-seeking behaviors among Pacific Islander migrants in the United States (Aitaoto et al. 2009; Choi, 2008; Williams & Hampton, 2005; Wong & Kawamoto, 2010). Outreach to Marshallese and Chuukese women utilizing lay educators, providing materials and education in the native language and provided in
church settings with the support of the pastor was recommended in the study by Aitaoto et al. (2009). Providing education regarding women’s health should be done by a woman, and women’s meetings were recommended as a venue for educating Chuukese women regarding women’s health issues (Wong & Kawamoto, 2010). Recommendations to decrease barriers to health care faced by Marshallese migrants in the United States included providing translators, providing health and social service information in Marshallese, and using Marshallese lay workers in conjunction with health care providers (Williams & Hampton, 2005). Choi (2008) also recommended educational strategies involving collaboration with Marshallese church leaders. Partnerships with church leaders could assist health care providers and policy makers develop programs that are more accessible and result in improved health for the Marshallese community in Hawaii (Choi, 2008). Key informants and Chuukese women participants in this study referred to church groups as a valuable resource. A strategy recommended by key informants was to collaborate with community leaders such as the local chief and church pastors when planning and implementing education to Chuukese migrants in Guam.

Educating migrants prior to departure to Guam or other U.S. destinations was recommended by several key informants in this researcher’s study of Chuukese migrant women. This finding was consistent with recommendations by Pobutsky et al. (2005) for culturally appropriate community-based interventions for Micronesian migrants. Plans to educate migrants prior to leaving their home country about health requirements were described and examples given of a project to produce videos made in Chuuk for migrants to learn what documents are needed prior to moving to Hawaii. Collaboration with public health officials in several Pacific Island countries was discussed, with plans to develop health teaching materials in Chuukese, Marshallese, and Samoan (Pobutsky et al., 2005). Key informants in this study of migrants in
Guam had similar recommendations for education of migrants before moving to Guam or other U.S. destinations. Education is needed regarding necessary documents and other requirements for receiving education, health, and social services. Key informants and the Chuukese women participants indicated that teaching prior to moving to Guam is not currently taking place.

**Implications for Nursing Education**

Educating nurses about the issue of health disparities and the concepts of marginalization and vulnerable populations can provide a foundation towards understanding the complex issue of health care disparities. Nursing education can improve the nurse’s understanding of providing culturally relevant health care. Increasing the nurse’s understanding of the complex social, economic, cultural, and political influences affecting health-seeking behaviors and the health status of migrants should be a goal of nursing education. According to the Institute of Medicine (IOM), the implications of health disparities for the U.S. health care system are significant (IOM, 2003). Educating nurses about the complex nature of disparities can be one effort to combat health disparities. The economic impact of the FAS migrants in Guam is significant and affects health care costs in the island (Government of Guam, 2005).

The women in this study perceived that they were mistreated by health care workers because they were Chuukese. Nurses and other health care workers can be educated on the concept of marginalization and the impact on vulnerable populations in order to prevent patterns of behavior that may further marginalize clients and add to their resistance to seek health care. The Chuukese women in this study reported feelings of poor treatment and mistrust of health care workers. They cited specific examples in which they had difficulty obtaining help in social and health care settings in Guam.
These perceptions related to the behaviors of health care workers that further marginalized these women. The Chuukese migrants in Guam are a vulnerable population suffering from disparities in health status. All but one key informant reported specific incidents in which Chuukese migrants were marginalized or treated badly by health care or social service workers. Vulnerable populations are at higher risk of suffering from health disparities (Meleis, 1996; Vasas, 2005). Educating nurses about these perceptions and the concept of marginalization are important steps to improve care to the Chuukese migrants in Guam.

The predominant ethnic groups in Guam (Chamorro, and Filipino) have cultural norms that differ from those of the Chuukese. Nursing education in the area of cultural competence is important. Understanding that Micronesians have differing cultural beliefs and practices are an important foundation for providing culturally sensitive health care (Pobutsky et al., 2005). The need to teach nurses about specific cultural considerations when working with Chuukese clients is important in Guam and other areas with high numbers of migrants. The cultural norms of male superiority, gender norms, the incest taboo, and their influence on the daily behaviors of Chuukese are specific areas for nursing education. Understanding the unique culture of the Chuukese can lead to increased cultural awareness. This increased cultural awareness can lead to the development of cultural competence among nurses and other health care professionals. Health care providers can be educated about culturally sensitive communication techniques. The appropriate tone of voice and facial expressions can have an important impact on the development of a trusting relationship with the client. Chuukese women articulated sensitivity to facial expressions of health care workers, describing fear when they perceived the health care worker to be “mean.” The feelings of being mistreated and fear can inhibit health-seeking behaviors for this marginalized population. Williams and Hampton (2005) cited a lack of
knowledge by health care workers on how to provide culturally competent care to Marshallese clients as a cause of some of the barriers to seeking health care services. Health workers who fail to acknowledge cultural differences can negatively impact communication. This negative effect on communication can lead to adverse health outcomes for the population. The importance of developing a trusting relationship between vulnerable populations and health care providers is essential to improving health outcomes (Williams & Hampton, 2005).

Another implication for nursing education is for nurses to be competent in health education techniques. The development of culturally relevant health education materials, and assessment of client health knowledge are important topics for nursing education. Assessment of the educational level of the Chuukese is important because of the differences in the educational systems in Chuuk and Guam. Nurses need to recognize that educational levels vary widely and the Chuukese system is quite different from the U.S. educational system. Migrants may not have received education in health concepts taught in U.S. middle and high school, and nurses cannot assume that they have an understanding of basic concept of health. Because of this limited education, nurses can individualize assessments to meet the client’s needs. During the study, it was evident that many of the participants were not able to read the Chuukese translation of the consent form and required assistance to complete the demographic questionnaire from the researcher and Chuukese translator. Providing materials translated into Chuukese will not meet the needs of many migrants, and this is an important consideration for nursing education and practice. It is important to teach nurses to take the time to evaluate a client’s baseline knowledge, literacy, and language skills before implementing health education.

Implications for Nursing Practice

The recommendations made by this study’s participants can assist nurses, policy makers,
and other health professionals in planning more effective interventions to decrease disparities for this marginalized population, and add to the body of knowledge about the Chuukese people. The Vulnerable Populations Conceptual Model described in Chapter 2 has a community health perspective. The availability of resources, risk factors faced by the vulnerable population, and health status are interrelated. As societal and environmental resources are unavailable, the relative risk increases and leads to a decrease in the health status of the vulnerable population. The Model postulated that the nursing profession can influence resource availability, relative risk, and health status through nursing practice, research, and policy analysis (Flaskerud & Winslow, 1998). The findings of this study of Chuukese migrant women can assist in improving health outcomes through increased knowledge of this vulnerable population. The knowledge gained can provide guidance in the areas of nursing practice, education, and research. One goal of this study was to increase knowledge about the health-seeking behaviors and barriers to care among the Chuukese migrants in Guam. Although the findings cannot be generalized to all Chuukese migrants in Guam and the United States, the findings can assist health care providers, nurses, and policy makers to plan strategies to improve health outcomes for this population. The study findings supported that health-seeking behaviors are affected by factors more complex than just financial and insurance barriers. Social and cultural factors influenced health-seeking behaviors and this study provided a view of the unique perceptions of Chuukese migrant women in Guam; it represents one of the first times their voices have been heard.

Recommendations to improve health care included increased availability and utilization of appropriate translators in the acute care setting. The lack of appropriate translators in the hospital setting was found to be a significant barrier. Key informants reported that employees who were fluent in Chuukese, but not hired as translators, may be called upon based on the
discretion of the health care professional. Many participants reported the use of family members with English language proficiency as translators. The use of family members as translators was not advocated except in emergencies and when a translator was not available. The use of family members as translators posed concerns regarding confidentiality, conflicts of interest, and interpretation competency (Youdelman & Perkins, 2005). This study of Chuukese women found that the use of family or bilingual employees (rather than dedicated translators) was not adequate to meet the linguistic needs of this population. Public health clinics have increased their staff of Chuukese translators and this is a positive step. In 2011, two of the three public health centers hired full time Chuukese translators. The hospital did not, however, have dedicated translators. The development and implementation of policies regarding the use of translators in the acute care setting are important steps in improving the communication between Chuukese migrants and their health care providers. Miscommunications that occurred due to lack of translation services further impeded the provision of quality care to this migrant population. If bilingual employees are to be used rather than dedicated translators, policies defining their job duties, and evaluation of their competency as a translator should be implemented (Youdelman & Perkins, 2005).

A finding unique to this study and relevant to nursing practice was the concern that use of Chuukese translators may pose a barrier because of concerns that confidentiality may be breached. The provision of translators for Chuukese migrants as a means of diminishing barriers is recommended in the literature (Choi, 2008; Williams & Hampton, 2005). The finding, however, that the use of Chuukese translators can also pose barriers was not evident in the published literature. The confidentiality concerns should be addressed through training of Chuukese personnel who provide translation or other health services to Chuukese clients. The
legal and ethical issues and the view of confidentiality as a duty to clients must be reinforced. The importance of confidentiality must be explicitly shared with the Chuukese clients in order to gain their trust and encourage open discussions with their health care providers.

Understanding the variables that influenced health-seeking behaviors of the Chuukese can be instrumental in planning effective health care strategies. Another recommendation was to provide increased outreach services to the Chuukese population. The transportation barrier was a significant issue and the inadequate public transportation system in Guam did not provide a solution to decrease this barrier. Community-based outreach has been recommended in the literature on Pacific Islander populations (Aitaoto et al., 2009; Choi, 2008; Wong & Kawamoto, 2008). Outreach services can be expanded to provide increased education to migrants. The study findings clearly indicated a deficit in education that influenced health maintenance and health-seeking behaviors of the Chuukese. The need for sustained, continuous education with culturally and linguistically appropriate materials was evident from this study. All key informants gave specific recommendations for educational topics that were needed to improve health outcomes for the Chuukese community. Studies of Micronesian migrants in Hawaii referred to the ongoing development of teaching materials that were culturally and linguistically appropriate for Chuukese, Marshallese, and other Micronesian migrant groups (Pobutsky et al., 2005; Pobutsky et al., 2009). Another implication for nursing practice was to develop teaching materials that are culturally and linguistically appropriate for the Chuukese community. When developing education materials, it is important to take into account the varied reading abilities of the Chuukese.

Assessment of how Chuukese received health-related information is an important consideration before planning an educational intervention. In a study of Pacific Islander women
in Hawaii on strategies to increase screening practices for breast and cervical cancer, researchers studied the means by which women from different ethnic groups received health information. Chuukese and Marshallese participants reported receiving health information from trusted leaders including their pastor or civic and social leaders. Television was not a means of obtaining health information as the survey reported no Marshallese or Chuukese (0%) relied on television as a source of health information. Only 17% of Marshallese and Chuukese participants reported health care providers as their source of health-related information. Health related information was primarily received through their social, cultural network (Aitaoto, et al., 2009).

Development of relevant teaching materials and finding the most appropriate means to disseminate the information was an important aspect in planning education interventions. As discussed in the implications for nursing education, however, it is important to evaluate the level of education of the Chuukese migrants before implementing any teaching interventions. Simply providing materials written in Chuukese would not be adequate to meet the needs of many Chuukese who are unable to read their own language. There is a need for nurses to advocate for the provision of health education in the Chuukese language in both oral and written form.

The Chuukese women in this study were familiar with prenatal care and immunization needs due to school and work-related requirements in Guam. The outreach efforts providing immunizations in community settings have resulted in the Chuukese women’s compliance with and knowledge of the need for immunizations. This knowledge, however, did not apply to other preventive health services such as women’s health or chronic disease screenings for diseases such as diabetes and hypertension. The implication for nursing practice is the need for education targeted at disease prevention and health promotion beyond immunizations and prenatal care.
The literature supported this researcher’s findings regarding the need for further health education. Choi (2008) recommended provision of health services that were more linguistically and culturally appropriate. The researcher cited the negative effects of reliance on a parochial network for health information that may be ameliorated with interventions that are more effective. Although the Marshallese in Choi’s study (2008) did not seek preventive care services, the study findings indicated that the familiarity with policy requirements for tuberculosis testing, and other school or work-required immunizations resulted in high rates of immunizations among the population. This example of immunization compliance supported the finding that cultural factors influencing health care can be positively influenced by strong policy and consistent education from health care providers (Choi, 2008).

The study data revealed the need for increased cultural sensitivity and competence for nurses working with Chuukese migrants. The lack of understanding of the cultural norms such as the gender norms, incest taboo, and status of women affected the provision of culturally competent nursing care. As discussed in the implications for nursing education, Chuukese women described heightened sensitivity to the tone of voice and facial expressions of the health care workers. Women cited long wait times in the clinic or hospital as excessive and perceived the long wait times as a lack of concern by health care providers. The lack of trust and perception of poor care were evident in discussions with the women participants. Perceptions of poor treatment and lack of caring on the part of the health care worker influenced the health-seeking behaviors of some Chuukese migrants. Awareness of the existence of this perception among some Chuukese is important for nurses working with this population. Providing information to those waiting to receive care may alleviate the concern that their needs were being ignored due to lack of concern or prejudice.
The influence of the gender norms, the status of Chuukese women, and the complex avoidance behaviors are important aspects of Chuukese culture not widely recognized by most Guam residents. The superiority of males in Chuukese culture was a significant cultural value (Moral, 1998). Several aspects of the gender norms are significant to nursing practice in the areas of direct patient care and communication. While focus group participants did not cite the gender of the health care provider as a barrier, several Chuukese key informants described significant gender issues for female Chuukese when the health care provider is a Chuukese male. They stated that for Chuukese males, the issue of receiving care from a female provider is less of a problem than it is for Chuukese females to receive care from Chuukese male providers. They were strong in their recommendation that Chuukese females should not receive care from Chuukese males in a health care setting. Nurses can assess the individual needs of Chuukese female patients with the awareness that gender issues may arise when providing care. It cannot be assumed that providing a Chuukese health care worker without regard for gender is culturally appropriate.

The value of male superiority in Chuukese culture has implications in terms of communication. A female Chuukese key informant described the expectation that male Chuukese were to be treated in a respectful manner. This included the tone of voice used when speaking to a Chuukese male. The tone must be subdued and respectful. The predominantly female nursing workforce, combined with the lack of understanding of Chuukese male superiority lends itself to miscommunication and unintended, culturally inappropriate care. A Chuukese key informant described the expectation that Chuukese men have of communicating with women. Women are expected to use a low, respectful tone of voice and speak in a gentle manner. She further stated that nurses who speak in a loud tone with an authoritative manner
would offend Chuukese males. A direct, straightforward approach and a loud or directive tone of voice would be perceived as disrespectful and inappropriate. The Chuukese male would not be inclined to interact with the nurse in a cooperative manner. By incorporating the findings of cultural influences into nursing practice, nurses can provide culturally competent care. Increased knowledge of cultural expectations and norms will assist nurses to provide culturally competent care for Chuukese migrants. Through appropriate communications, both verbal and nonverbal, nurses may be able to develop trusting and caring relationships that may encourage appropriate health-seeking behaviors. Williams and Hampton (2005) cited perceptions of prejudice and discrimination among health care workers that influenced the health-seeking behaviors of Marshallese migrants leading to care that was ineffective and resulted in negative health outcomes. The implication for nursing practice is to improve knowledge of the culture and provide care that is culturally relevant to meet the needs of this vulnerable population.

Nursing practice provided in collaboration with community leaders is vital to improve education and care for Chuukese migrants in Guam. An important element in accessing migrant communities in Guam is through the cooperation of Chuukese community or church leaders. The support of community leaders was important when planning outreach or research efforts in the various Chuukese communities on the island. When planning this research study, the women participants in a particular Chuukese community stated that the consent of the Chuukese chief was necessary before they would participate in focus groups. A key informant who provided health outreach to the Chuukese community also noted that collaboration with the Chief or other community leader was essential when planning an outreach event. The literature supported the finding that community and church leaders played a significant role in the communities of
Pacific Island migrants and their support was vital to successful community education efforts (Aitaoto et al., 2009; Choi, 2008; Williams & Hampton, 2005).

**Implications for Nursing Research**

The information gained from this study added to the knowledge about Chuukese women and barriers to their health-seeking behaviors. There is a need for further research with Chuukese and other Pacific Island migrant populations. More research is needed with other populations of Micronesian migrants in Guam from the Freely Associated States. The information gleaned from the Chuukese women cannot be generalized to all Micronesian migrants in Guam. Further study of barriers and health-seeking behaviors of other Micronesian groups can contribute to information that can be used to decrease disparities and improve health outcomes. The current body of literature supported the need for further research with Micronesian migrants in the United States. (Choi, 2008; Shoultz et al., 2007; Williams & Hampton, 2005; Wong & Kawamoto, 2008). This study identified areas for further research with the Chuukese people in Guam.

This study revealed an important finding regarding confidentiality concerns when working with Chuukese translators. This finding has not previously been addressed in the literature. This issue warrants further study and dissemination of information. It was clear from validation with the Chuukese women and the key informants that this was an important issue to address when working with Chuukese translators and the Chuukese clients seeking care. Further research can be done to validate the findings of this study and to examine if confidentiality when using translators from the same ethnic group is a concern for other Micronesian migrants groups.

The use of local Chuukese medicine needs further exploration. The study findings were not clear as to the extent to which Chuukese utilize local-Chuukese medicine. Women gave
varied accounts of when they would use local Chuukese medicines. Some women reported using local remedies before seeking Western medical care, while others reported using local remedies when western methods were perceived to be ineffective. Key informants had the perception that barriers to health-seeking behaviors such as financial constraints and lack of transportation influenced the Chuukese to try traditional medicines as an alternative to seeking Western health care. Further nursing research should be conducted to explore the use of Chuukese medicines and health practices.

The role of Chuukese women and the changing structure of the family unit from extended family to nuclear family and loss of cultural factors that were protective of women have been noted in the literature to place women at risk for increased stress and family violence (Magnussen et al., 2011; Shoultz et al., 2007). The issue of intimate partner violence was not a focus of this study; however, in light of the social, economic, and cultural factors influencing health-seeking behaviors, further research with Chuukese women is warranted. Moral (1998) attributed an acceptance of domestic violence and increase in the power of Chuukese males to the change in family structure. Future research on women’s health needs is warranted to examine the influence of the barriers identified through this research.

Nursing research on the meaning of health to Chuukese migrants could further increase knowledge about this population. While the study of Marshallese revealed health beliefs that affected their decision to seek health care (Williams & Hampton, 2005), further research on Chuukese health beliefs and the influence on their health-seeking behaviors remain to be accomplished. Choi (2008) identified group orientation and interdependency as factors influencing health-seeking behaviors. Marshallese migrants in Hawaii had a strong reliance on migrant networks for obtaining health care. These network members act as lay referral systems
and decision makers who have tremendous influence on the health-seeking behaviors of the Marshallese migrants (Choi, 2008). The source of health information for Chuukese migrants needs further exploration. Both Marshallese and Chuukese migrants in Hawaii reported community leaders such as the pastor or other leaders as their source of health information (Aitaoto et al., 2009). Further study of the means by which Chuukese migrants obtain health information should be done and can assist in planning how best to reach this population. Nursing research to develop culturally relevant health education interventions may lead to increased preventive health-seeking among the Chuukese. An emphasis on community participation in the research process can assist in the development of culturally appropriate strategies. Community-based strategies and research involving community participation can assist in providing effective health teaching and improve the health outcomes for Pacific Island migrants (Pobutsky et al., 2005).

**Study Limitations**

There were several limitations to this study. The women focus group participants were all from migrant families with household incomes reported to be less than $10,000 per year. None of the participants reported using a private clinic or health care provider as their usual source of health care. The socioeconomic status of the participants may have influenced the study findings regarding barriers, mistreatment, and marginalization. All participants used the public health clinics or the local hospitals as their usual source of health care. All participants had limited educational backgrounds, with the majority completing only elementary education. The educational level may have influenced the findings in the area of communication barriers. All the women reported speaking Chuukese as their primary language and needed assistance from the
translator to complete the demographic and consent forms. The social and economic factors as well as limited acculturation influenced their perceptions and experiences.

The exclusive focus on Chuukese females is a limitation. The significant gender norms and avoidance behaviors limited the ability of the researcher to interact with Chuukese males. Therefore, research was conducted with 21 Chuukese females. The findings from the women cannot be generalized to male Chuukese migrants. Generalizability of the findings is also limited due to the use of a convenience sample. The small sample limited transferability of findings to all Chuukese migrant women. The study was conducted in the limited geographic region of Guam, and this limited transferability to other Chuukese migrant population in different locations. Although the study findings cannot be generalized to all Chuukese migrants in Guam, the findings do add to the limited knowledge base regarding the Chuukese women and barriers to health-seeking behaviors. The finding of cultural influences shaping the lives of Chuukese women added to the knowledge base of Micronesian cultural groups in Guam.

The wide diversity among Asian American Pacific Islander populations in the United States has led to issues in data reliability. The small sample sizes of these ethnic minorities are also an issue in data reliability. In order to understand and develop effective strategies for decreasing disparities among these ethnic populations, more data and knowledge are needed about the individual subgroups (Ghosh, 2003; Louie, 2001; Srinivasan & Guillermo, 2000).

The researcher had no understanding of the Chuukese language and the inability to communicate was a limitation. Although some efforts were taken using a female Chuukese translator, back translation, and member checking for verification of findings, meanings and subtle nuances may have been missed in the translation. This communication barrier limited the ability of the researcher as the focus group moderator to ask further probing questions. The
translator provided interpretation; however, at times there was difficulty in translating some Chuukese words into English. The translator was from an outer island, Polowot, and differences in dialect may have been a limitation. Participants were from different regions of Chuuk, with some participants from the main island, while others were from outer islands. There were minor differences in language, which was also a limitation, and an issue in data reliability. Translation and back translation were utilized to minimize errors in translation, and both translators verified the accuracy of the female translator’s work. The use of translation and back translation added to the reliability and credibility of the study findings. The back translator noted that the women seemed to speak freely to the researcher despite the researcher’s inability to speak Chuukese. Facilitation of groups by a non-Chuukese researcher may have contributed to open discussion by the women. The confidentiality concerns voiced by the women and supported by key informants reinforced the appropriateness of a non-Chuukese researcher. The researcher was not a member of their communities and therefore the women did not fear that the researcher would share their information with other Chuukese.

**Summary**

Barriers faced by Chuukese migrant women in Guam were financial issues and difficulty obtaining health care due to long wait times and transportation problems. Difficulty communicating with health care providers and struggles with the language were additional barriers cited by study participants. The barriers of financial issues, transportation problems, and communication difficulties are supported in the literature. A perception of mistreatment by health care workers was evident. The women relayed a mistrust of health and social services. The language and cultural barriers contributed to mistrust and marginalization of the Chuukese
migrants. The literature supported the findings related to mistrust exacerbated by linguistic and cultural barriers.

Additional themes that described the experiences of the Chuukese women included social and cultural influences affecting health-seeking behaviors. These factors were the use of traditional Chuukese medicines and lack of preventive care services (beyond prenatal care and immunizations). Cultural factors included the Chuukese gender norms, the role of women, and confidentiality concerns when working with Chuukese translators. The finding of confidentiality concerns was not reflected in the literature and was unique to this research study of Chuukese migrant women in Guam. The theme of educational needs emerged from key informant data. There was a consensus among key informants that immense educational barriers existed and influenced the health-seeking and health-maintaining behaviors of the Chuukese migrants. The themes of educational needs and lack of preventive care were supported by qualitative research studies on Micronesian migrants in the United States.

Implications for nursing education were presented. Nursing education can play a role in combating the complex problem of health disparities. Understanding the processes that contribute to marginalization of vulnerable populations was an important step towards improving health outcomes for populations faced with health disparities. Educational strategies that are culturally and linguistically appropriate have the potential to improve knowledge of health and health care needs. Educating nurses and other health professionals about the Chuukese culture can facilitate the provision of culturally sensitive care. Educating nurses to communicate appropriately with Chuukese migrants can foster the development of a trusting relationship. This trusting relationship provides a strong foundation from which to positively effect changes in health-seeking and health-maintaining behaviors.
Further nursing research can be conducted to add to the knowledge of Chuukese and other Compact migrants. Understanding barriers to health-seeking behaviors is the first step towards improving health care and health outcomes. Future research on cultural gender norms and the role of Chuukese women may improve the understanding of Chuukese culture. Exploration of the use of Chuukese medicines is also warranted. Nursing research on health beliefs and the means by which Chuukese migrants receive health information can be undertaken to further the understanding of cultural influences on health-seeking behaviors.

The socioeconomic background of the study participants, convenience sample, and the sole focus on Chuukese women were limitations of this study. The study findings cannot be generalized to all Chuukese migrants. The inability of the researcher to speak and understand the Chuukese language was another limitation. Despite the limitations, this study added new information to the body of knowledge of Micronesian migrants in the United States, and in particular, of Chuukese migrants in Guam. Most of the study findings were validated in the current literature.

The recommendations made by the study participants to improve care to the Chuukese migrant population are important to consider. The study findings can assist policy makers, nurses, and other health professionals in planning, developing, and implementing effective strategies to improve health outcomes for this population. Future goals are to decrease health disparities experienced by Chuukese migrants in Guam. Chuukese women were open and shared their perceptions with the researcher. Women and key informants expressed an urgent need for improvement in the health and social service systems in Guam. There was a call to action from participants and a strong desire to achieve the mutual goal of improved care for Chuukese migrants in Guam.
References


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Map of Micronesia from: http://www.simpleworldmaps.com/micronesia.jpg
Appendix B

Map of Chuuk State

Map of Chuuk from: http://www.soest.hawaii.edu/MET/Enso/map/usapi/chuuk.html
Appendix C

Focus Group Participant Demographic Data Sheet

1. What is your age? ______________________________

2. When did you move to Guam? __________________

3. What is language do you speak most often in your home?  
   ○1. Chuukese  
   ○2. English  
   ○3. Other __________

4. What is the level of education you have completed?  
   ○1. Grade school  
   ○2. High School  
   ○3. Associate Degree  
   ○4. Baccalaureate Degree  
   ○5. Other __________

5. What is your island of origin? __________________

6. What is your total household income?  
   ○1. less than 10,000  
   ○2. 10,000- 20,000  
   ○3. 20,000- 30,000  
   ○4. 30,000-40,000  
   ○5. 40,000-50,000  
   ○6. >50,000

7. How many children do you have? ________________

8. How many people live in your home? ________________

9. What is your usual source of health care?  
   ○1.Public Health A  
   ○2.Public Health B  
   ○3. Public Health C  
   ○4. Hospital A  
   ○5. Private Clinic/Doctor ____________  
   ○6. Other ________________  
   ○7. None
Appendix D

Focus Group Participant Demographic Data Sheet

1. A fitu ieerumw? __________________________

2. Inet ka etto nonomw Guam? _________________

3. Fosun ia ka kon fofos ika kakapas non me non imwomw? ○1. Chuukese ○2. English ○3. Other _____________


5. Ifa wesetan fonuomw? ______________________

6. Ifa ukkukun moni tonong non neimwomw? ○1. kisi seni 10,000 ○2. 10,000- 20,000 ○3. 20,000- 30,000 ○4. 30,000-40,000 ○5. 40,000-50,000 ○6. >50,000

7. A fitemon noumw? ______________

8. Ou fitemon chon nonomw non imwomw? ______________

Appendix E

Focus Group Questions

1. Please tell us your name and how long you have lived in Guam.

2. What do you think is “good health care”?

3. Can you describe when you would seek health care services?

4. What are the main health problems affecting your health and your family’s health?

5. What are the main barriers that you encounter when trying to obtain health care for yourself and your family?

6. What are your experiences with health care in Guam?

7. Have you ever felt that a health care worker treated you badly? Please describe your experience and how you felt.

8. When would you or your family prefer to use traditional Chuukese medicines?

9. If you could suggest anything to improve health care for Chuukese in Guam- what would that be?

10. Is there anything else about this topic that you think I should know?

11. Do you have any concerns that have not been addressed today?
Appendix F

Focus Group Questions

1. Kose mochen areni kich itom me pwan nangataman omw ka nonomw won Guam.

2. Omw ekieki nge met wewechun “tumunuochun inisich ren samau”?

3. Kopwe arenie iusun inet omw kopwe kuta ekkewe pekin aninis ren tumumwunuochun inis seni samau?

4. Met ekkewe sakkun samwau mei toruk pwan tori chon non omw famini?

5. Met ekkewe mettoch mei esenipa an epwe epeti sonuk omw kopwe kutta pekin safei me tumunuochun inisum me chon omw famini?

6. Met mei fis ngonuk ren omw kutta pekin aninis ren safei ika tumunuochun inisum me won Guam?

7. Mei mwo fis ngonuk an ekkewe chon aninis ren pekin safei fakkun ngaw ar angang ngonuk? Kose mwochen kopwe apworousa ika ifa usun me pwan mefiom ren.

8. Inet en ika chon non omw famini re ekieki me finata nge repwe aea safean Chuuk?

9. Ika kopwe aninis ren mefiom an epwe aoechueno pekin safei ren chon Chuuk me won, epwe ifa sakkun?

10. Mei wor mefiomw ren ach ei porousen pekin safei en mi ekieki nge mei namot ai upwe sinei?

11. Mei pwan chuen wor met mefiomw ika met ke mwochen sinei, use pworous usun ikkenai?
Appendix G

Interview Guide: Key Informant Interviews

Thank you for your willingness to participate in this study. This research will contribute to uncovering and understanding the perceptions and beliefs of Chuukese migrant women regarding barriers to care and the factors that influence their health-seeking behaviors. A goal of this research is to make recommendations to decrease these barriers and improve health care for this population.

1. What types of health problems do Chuukese migrants have most often?
2. What kinds of problems do Chuukese migrants have in getting good health care?
3. What kinds of problems do Chuukese migrants have in maintaining good health?
4. Where do you think Chuukese migrants are most likely to go when they need health care?
5. Have you observed Chuukese migrants in Guam being marginalized or stigmatized?
6. If you could suggest anything to improve health care for Chuukese in Guam- what would that be?
7. Is there anything else about this topic that you think I should know?
8. Do you have any concerns that have not been addressed today?
Appendix H

CONSENT FORM
Chuukese Migrant Women in Guam: Perceptions of Barriers to Health Care

This is a qualitative nursing research study concerned with identifying the barriers to health care perceived by Chuukese migrant women living in Guam. The study will be conducted in two separate sessions. The first part of the study will be conducted through a focus group session which will last for 45 minutes to two hours. You will be asked to describe your experiences and perceptions regarding health care in Guam through a series of 11 questions asked to each group member. Before the focus group begins, you will be asked to fill out a brief demographic form with such questions as age, length of time in Guam, number of children, and other such demographic questions. A second session will be conducted to ask you to verify the researcher’s findings and interpretations of your information from the first focus group session. The second session will last from 30 minutes to one hour. All focus group sessions will be audio taped with a tape recorder. A second digital recording device will be utilized as well to enable the focus group data to be entered into a computer.

The risks to you in this experiment are, at most, minimal, and do not differ in any qualitative way from those you might experience in everyday life; however, you may experience slight anxiety in answering the questions. Your participation will help to further our knowledge of the perceptions and beliefs of Chuukese migrant women regarding barriers to care and the factors that influence health-seeking behaviors. Your perceptions and recommendations to decrease these barriers will be shared with the health care community, as there is little existing research on this topic.

You should understand that your participation in this experiment is completely voluntary. You have the right to have any questions answered before, during, or after the experiment. You may refuse to participate prior to beginning the study and you may also terminate your participation at any time, for whatever reason without penalty.

All data collected in this study will be kept entirely confidential. Your name will never be publicly associated with this experiment and your participation will be kept confidential. Personal information will be collected only for sample description purposes and this information will be kept in a locked filing cabinet, using an assigned code number. All other data will be kept under lock and key and in a locked computer under an assigned number. During the study all tapes and digital recordings will be kept under lock and key and will be erased after study completion.

If you have any questions concerning your participation in this project or your rights as a research subject, you should contact Dr. Maria Salomon, University of Guam School of Nursing & Health Sciences at 671-735-2650 or Dr. Suzanne Smeltzer, Chair of the Villanova Institutional Review Board at Villanova University (610) 519-6828.

If you agree to participate in this study, please sign below.

Name ________________________  Witness ________________________

Date ________________  Date ________________
Appendix I

Taropwen Mwumwuta
Fiin Chuuk Won Guam: Kunaowm ren Epetin Kutta Aninis ren Pekin Safei

Iei ewoch an kangof kaeo ngeni fan itan epwe asina cochu ekkewe metoch ra fis pwe epetin ach fin Chuuk won Guam feino ngeni kutta aninis ren pekin safei. Ei kaeo epwe ruu (2) kinkinin. Aewon kinkin epew faniten ew kukunun mwichen fefin ar repwe poporous me pwan ponueni ekko kapas eis non epwe ukukun 45 minich ngeni 2 awa. Ach tungor ngonuk omw kopwe aporousa usun met me fiftis ngonuk me won Guam me pwan pusin pwarata mefiom ren pekin safei me won Guam non omw kopwe ponueni ekkei 11 kapas ais fan itan emon me emon neich. Me mwan ach sipwe pwopwuta, sia mwochen tungor ngonuk omw kopwe amasowa ren ponueni ekko manapen kapas ais ren ierenum, inet fansoun omw nonomw Guam, iteiten noumwm semirit, me pwan ekko kapas ais. Aruuan kinkin ach chufengen epwe faniten ach sipwe tungor omw kopwe chekki fichi ren ennetin ika pwe kunaeen me awewen seni ewe mine chon fori ei pekin kaeo me pung ngeni met ii a angei seni rongean me non ewe aewin kinkin. Ukkukun ach fansoun poporaus non ei aruuan kinkin epwe 30 minich tori ew awa. Meinisin ach poporaus non ach mwicheich epwe teip. Epwe pwan teip on ewocho sakkun teip ren an epwe tongeni katonong meinisin non kampiuter.

Ren omw ka fitti me choni ei pekin kaeo, esap fakkun won afeiengawan ngonuk, esap pwan sokkono nonorum seni met en mei fen nonomwuni iteiten ran; nge esap mwan seni kopwe chok mefi ekis nuokusun me pireiren omw kopwe ponueni ekko kapas ais. Omw ka choni ei pekin kaeo ngeni epwe fakkun anisi me anepano ach weweit met an fin Chuuk won Guam wewe, memef me nukku ren met ekkewe a fis pwe pekin apetti kutta pekin safei me nonomochun me nimonimochun inisich. Mefiomw me met ekkewe ka ereni kich fan iten akukununon ekkewe pekin eppet ren kutta pekin safei epwe no ngeni ewe mwichen pekin aninis ren safei me won Guam, pwun mei fen fat nge mei fakkun kisikis pekin kaeo ngeni ei sakkun nikikik.

Kopwe weweit me fat ren nge omw fiti ei pekin kaeo epwe pwusin mefiom. Mei wor omw pwung an epwe wor ponuen omw kapas ais me mwan, pwan fansoun acokos, me pwan wesinon ei pekin kaeo ngeni. En mei tongeni omw kosapw fiti me mwan poputan ei kaeo ngeni, en mei pwan tongeni towu seni ei pekin kaeo inet chok ka pusin mefi, ese pwan wor tipisin omw kopwe tou.

Meinisin met kich mei angei me ioni seni ei pekin kaeo epwe fakkun nukununuko esap wor epwe angei. Itomw esap tongeni pwe pna gei emon choni ei pekin kaeo ngeni. Tichikin poraupen inisum epwe fan iten chok kapas manapen ei kaeo nge meinisin epwe fakkun nukununuko non ekkewe kapet mei wor nokkun. Meinisin pwan ekko ekkewe ekkewe metoch sia ioni me angei epwe nomw non kampiuter nge epwe nook, mei wor chok ion epwe kafinino an epwe tongeni angei. Pwan meinisin ekkewe met mei nomw won ekko teip repwe pwan nomw non ew neni mei nokkun me kian nge meinisin repwe kamoronon fansoun a wes maken ei pekin kaeo.

Ika pwe mei wor omw kapas ais fan itan omw kopwe choni ei pekin kaeo ika ren omw pwung ren omw choni ei pekin kaeo, kopwe kokori Dr. Maria Solomon, University of Guam School of Nursing & Health Science ren ewe tengewa 671-735-2650 ika Dr. Suzanne Smeltzer, Chair of the Villanova Institute Review Board at Villanova University (610) 519-6828.

Ika pwe en mei tipeew ngeni omw kopwe fiti ei pekin kaeo ngeni, kose mwochen sainei fan.

Itomw ___________________________________ Chon Pwarata ___________________

Ranin maram ___________________________ Ranin Maram __________________
Appendix J
CONSENT FORM
Key Informant Interview
Chuukese Migrant Women in Guam: Perceptions of Barriers to Health Care

This is a qualitative nursing research study concerned with identifying the barriers to health care perceived by Chuukese migrant women living in Guam. The study will be conducted in two separate planned interviews. The first interview will last for 45 minutes to one hour. You will be asked to describe your thoughts and perceptions regarding health care for Chuukese migrants in Guam through a series of 8 questions in an interview style format. A second session will be conducted to ask you to verify the researcher’s findings and interpretations of your information from the first interview. This will be conducted via telephone or in person and will last no more than 30 minutes. All interviews will be audio taped with a tape recorder. A second digital recording device will be utilized as well to enable the data to be entered into a computer.

The risks to you in this experiment are, at most, minimal, and do not differ in any qualitative way from those you might experience in everyday life; however, you may experience slight anxiety in answering the questions. Your participation will help to further our knowledge of the perceptions and beliefs of Chuukese migrant women regarding barriers to care and the factors that influence health-seeking behaviors. Your perceptions and recommendations to decrease these barriers will be shared with the health care community, as there is little existing research on this topic.

You should understand that your participation in this experiment is completely voluntary. You have the right to have any questions answered before, during, or after the experiment. You may refuse to participate prior to beginning the study and you may also terminate your participation at any time, for whatever reason without penalty.

All data collected in this study will be kept entirely confidential. Your name will never be publicly associated with this experiment and your participation will be kept confidential. All study information will be kept under lock and key and in a locked computer under an assigned number. During the study all tapes and digital recordings will be kept under lock and key and will be erased after study completion.

If you have any questions concerning your participation in this project or your rights as a research subject, you should contact Dr. Maria Salomon, University of Guam School of Nursing & Health Sciences at 671-735-2650 or Dr. Suzanne Smeltzer, Chair of the Villanova Institutional Review Board at Villanova University (610) 519-6828.

If you agree to participate in this study, please sign below.

Name ________________________  Witness_______________________

Date ________________  Date___________________
Script to Solicit Focus Group Participants:

Hello Ma’am:

My name is Margaret Hattori, and I am a nurse conducting research with Chuukese women in Guam. The purpose of this study is to discover what barriers to health care are perceived among Chuukese migrant women in Guam. I would also like to find out what factors may be influencing your health-seeking behaviors and to obtain your recommendations to improve care for Chuukese in Guam.

Your perceptions and recommendations to decrease these barriers will be shared with the health care community. Your participation will help increase our knowledge of the Chuukese migrants in Guam and the barriers they face in seeking health care.

The study will be conducted in two separate focus group sessions. All data collected in this study will be kept entirely confidential. Your name will never be publicly associated with this experiment and your participation will be kept confidential. As a token of appreciation for your time and sharing your experiences, a $25 gift card will be given to you at the completion of the second focus group session. I appreciate your consideration and assistance in conducting this study.
Ran annim

Itei Margaret Hattori ngang emon kango f uwa fori ai pekin kaeo ren fiin Chuuk me won Guam. Akauchean ai ei pekin kaeo an epwe kutta ika met ekkwe mettoch epwe fis pwe eppet ngeni an fiin Chuuk resap feino ngeni pekin safei. Uwa pwan mwochen kutta ika met ekkewe metoch epwe esenipa ren omw koppe ika kosapw kutta pekin aninisin safei, upwe pwan angei mefiom ika met sipwe fori an epwe eochuno aninisin safei ren chon Chuuk me won Guam.

Met kunaomw me mefiomw ren an epwe akitano ekkewe metoch mei efisi an epwe eppeti aeo chunon safei ren chon Chuuk, epwe esinesin ngeni ekkewe chon angangen safei won Guam. Omw aninis epwe esenipa an epwe aeo chunoch anach weweiti me sinei ochu nonomun chon Chuuk mi nomw won Guam me ekkewe metoch a afisi pwe appetin ar repwe kutta pekin aninis ren safei.

Ei pekin kao epwe fis non ruu kinikinin. Meinsin met sipwe an gei seni ei pekin kaeo, epwe fokkun nukunukuno, ese wor epwe tongeni sinei. Itomw esapw tongeni pwa ngeni chon anea pworousen ei kaeo. Fan itan ach fakkun kinnisou ngonuk ren omw fansoun me met ka apasa ngeni kich, ei $25.00 nifang epwe no ngonuk wesin ach sa wes ne poporous fengen ren ewe aruan kinikin. Ai fakkun kinnisou ngonuk ren omw aninis ren ach ei pekin kaeo.

Kinisou.
### Significant Statements and Content Analysis

#### Significant Statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Subcategories</th>
<th>Categories</th>
<th>Theme One</th>
</tr>
</thead>
<tbody>
<tr>
<td>The insurance—that is very important. We cannot see the doctor if we don’t have insurance.</td>
<td></td>
<td>Legal Concerns</td>
<td>Barriers to Seeking and Maintaining Health</td>
</tr>
<tr>
<td>Yes, because the ones who don’t have insurance cannot go to the doctor.</td>
<td></td>
<td>Financial Concerns</td>
<td></td>
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<tr>
<td>For Medicaid, they tell us how much to pay for co-payment. For example, if the medicine costs $20, they would pay for $10 and I would pay $10. For that, we wait until we have money, but when we have the money the prescription expired already because it’s been a long time that we’ve been holding onto it. Then it’s useless for us to buy the medicine because the prescription is expired already, we had it for a long time and we don’t have money for it, but if we do have money we get it right away.</td>
<td></td>
<td>Financial Concerns</td>
<td></td>
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<tr>
<td>Another problem is when they give us prescriptions for medicines. We have to go to the private pharmacies. And if we don’t have money, what are we going to do?</td>
<td></td>
<td>Financial Concerns</td>
<td></td>
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<tr>
<td>They don’t have insurance; they don’t have insurance because they lack jobs. For example, the husband will be working for a construction company that doesn’t provide medical insurance, or they work side jobs and don’t have health insurance. So, most of it has to do with health insurance, not having health insurance. Key informant (K7)</td>
<td></td>
<td>Financial Concerns</td>
<td></td>
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<tr>
<td>In maintaining good health, it goes back to the other question. Money. In order to be healthy, you need money. It is expensive to be healthy. It is expensive to eat right. It’s expensive to exercise sometimes. It’s expensive too, and if you have a chronic disease like diabetes or high blood pressure you have to maintain your medications, and so if the money runs out, you can’t afford to get your medications. Then the health care runs out and they don’t necessarily continue with what they need to do for themselves. Some of my clients don’t have power and water. Sometimes they don’t have refrigeration and so canned goods are the primary things they buy. It’s easy to go to McDonalds and buy a hamburger for a dollar rather than cook something that is healthy so that is an issue. Key informant (K7)</td>
<td></td>
<td>Financial Concerns</td>
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</table>
A lot of it is not having medical coverage. Not being able to pay for or going to see a doctor—that is the bottom line. Key informant (K1)

Maintaining good health, bottom line is money. A lot of them are unemployed, unemployed. Key informant (K1)

From the social standpoint, they don’t have enough money to get their medicines but they don’t know enough to apply for MIP [Medically Indigent Program] or Medicaid….and because a lot of them have just arrived on island before they come and seek medical attention, they’re not eligible to receive MIP until after 6 months and the private entities don’t take self-pay patients so they end up here. Key informant (K4)

For us there aren’t any problems because we have insurance, except transportation is one issue we face trying to seek health care. Now our car is broken down. So now I have to cancel my appointment tomorrow. I never ride on the public transit. But I think last year when we called transit they told us to walk down to the main road.

So these are the main things that we think is most needed and could help improve the health care delivery to the Chuukese people: to have health assistance through health insurance, translation services, and other possible solutions for the people with no means of transportation such as providing buses in order for them to reach the clinics.

Before they can give us a prescription and we can go anywhere, like a drug store in Agana. Now we have to go to the pharmacy in Dededo. We have to get the prescription and the referral. Before we used to go to any pharmacy and they accept MIP. But now, no more. Since maybe 3 months ago. If Dededo is closed we can go anywhere, but if it is open we have to go there for the pharmacy. We used to go to a pharmacy close by our home. But now it is very hard for us to go to Dededo. Sometimes we cannot go right away because of transportation. Sometimes we have to wait up to three days to get a ride to take us up to the pharmacy.

And if they try to go to public health, they need to arrange their ride. And maybe they have trouble getting to Public Health during the hours that they’re open. They may not have vehicles available when Public Health is open. Key informant (K4)
And another thing, I am so tired of going to that hospital because if I go there in the morning, I will be there until almost nighttime before I am finished. Another woman in the same group chimed in: “maybe 5 or 6 hours to wait.”

<table>
<thead>
<tr>
<th>Long Wait Times in Health Care Facilities</th>
<th>Difficulty Obtaining Health Care</th>
<th>Barriers to Seeking and Maintaining Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>That is one problem, the long wait. It seems like they don’t care about us. We go in and sit from morning to afternoon, we get hungry, cold. One time I came and waited until almost night. I came by and asked the nurses how long it would take. They would tell me to go back and have a seat and just wait. I almost just walked out. My son brought me to the emergency room. He was shivering from the cold so he had to go and wait outside in his car. It was a long time to wait.</td>
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<tr>
<td>Because you know when I go up to the hospital or the clinics, I see them waiting in long lines. You know, when you have to wait all day, and then they say we are closing at 5 and then you have to come back the next day. That is very frustrating. But if they have their own health insurance, they can walk into a clinic, anytime, anywhere. They don’t have to go to the hospital or the public clinics. They don’t have to wait in long lines. Key informant (K1)</td>
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<td>Having a translator is very important because we go in and we have a hard time trying to tell doctors what the problems are, not knowing how to say it in English. I can only say simple words and describe simple illnesses. But when it comes to having bigger issues I don’t know what to say.</td>
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<tr>
<td>It is good for those who speak English, but for others it is hard. They have to bring someone who can translate with them.</td>
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<td>My grandson—when he was admitted, someone that could speak English had to go and stay with the mom and child in the hospital. Maybe, that’s why it should be the first priority. So having a translator would help.</td>
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<tr>
<td>We could have a translator. Maybe that’s why some of the Chuukese don’t go see the doctor; because they have a hard time talking to the doctor. Maybe if there are translators then maybe it would be easier for them to go and seek health care.</td>
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<td>I feel sorry for the dental clinic. Some Chuukese, when they come, they can’t understand. When they give them paperwork to fill out, they don’t understand. They don’t know how</td>
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</table>
to fill out the paperwork. Some of them just take the papers and leave. Some ask other Chuukese to help them. That’s the problem.

That’s the other thing about Chuukese culture…everything is yes. Because that is just polite, that’s just proper. Even if I speak Chuukese, sometimes they’ll say yes. That’s why I prefer the translators because I can ask are you sure they understand. I can really ask if they are going to do this. Sometimes I tell them to do step one, then call me, and I’ll tell them to do what step two is, and then I’ll tell them what step three is. Key informant (K2)

They don’t come out right away and they don’t ask questions. Especially if they are not familiar with you, they don’t really feel comfortable with you, but they just say yes, yes, but in fact they don’t know. That’s really another issue, and that’s one of the reasons we have an interpreter so that they make sure they do understand what they are coming here for and we can find out what their health problem is. Key informant (K5)

They have the right to understand. We have the right to understand and to communicate. Key informant (K6)

One time we had a lady come in for a pap smear. She came in with her husband so I asked: “You and your husband will go into the room together?” So, first of all, they didn’t know the reason they were coming in. Yes, they knew they were coming in for the Pap smear, but they didn’t know what a Pap smear was. So I had to explain it to the patient. I said, “The doctor’s going to check your bottom, he’s going to put you on the table and he’s going to open your legs.” They just got up and left. They were not made aware of what a Pap smear was before they came in for the appointment. Sometimes they don’t ask questions, so you just assume they know. K5

I know we have three employees that are Chuukese. They work in different jobs. We don’t have a dedicated translator. But there is a list given to them [health care workers at the hospital], a list of translators. We do have people in the hospital that serve as translators. We don’t have one that sits there in the emergency room. Key informant (K4)

I have some educational materials translated into Chuukese, but some of the Chuukese don’t read Chuukese so my teaching is mostly done verbally. So it works well when they bring a translator. We actually have a Chuukese employee in our school so sometimes I’ll
grab her out of her classroom and have her help me translate if it is that important to me.

Key informant (K2)

<table>
<thead>
<tr>
<th>Inability to Communicate with Health Care Providers</th>
<th>Communication Issues</th>
<th>Mistrust Resulting from Communication Barriers</th>
<th>Barriers to Seeking and Maintaining Health</th>
</tr>
</thead>
</table>

The skin all over my body was very swollen. I went to the hospital and the doctor said that is an infection—just give the trick. I don’t know what kind of trick. I was praying and asked God to touch his heart so that he can feel how much pain I have. That is the only thing that I did that night. Then they gave me the paper for the medicine. I went to the pharmacy, I bought the medicine and it did not work. There is no use for me to go back to the hospital. They said they are going to do the trick. So what kind of trick are they going do.? She paused for a minute, and then went on. They really said that. That’s the word coming out from the doctor’s mouth. “The trick.”

And the second time I went there last April and the doctor said the sores are an infection and we’re going to do the trick. I don’t know what kind of trick. That’s the thing that stuck in my brain.

What about the case workers in food stamps and welfare, can we talk about them too? Because I helped one lady, she lived with me before. And she was really crying because she cannot speak English. The case worker was screaming, and I tried to help her to talk to the case worker but the caseworker told me “You know what, she has to speak English.” I tried to explain that she cannot speak English. The caseworker replied, “You are done, you cannot help her, and you can get out.”

It shows that the lady does not want to help us Chuukese. She will help only those who can speak English well enough to answer her. Unlike those of us who don’t really know English—we would just answer yes/no to whatever and the will not help us understand. They wouldn’t care and won’t bother to help us. The first case worker that helped me apply for food stamps was a lady. That lady, she was really mean. She didn’t want anybody to help me. My niece came with me to help me. The case worker told her to leave. She said nobody should help me, I should do it myself.
Significant Statements

For example, they use it for colds and fever, Chuukese use medicine specifically made for the illness.

We use it only for our babies. When they are sick then we use Chuukese medicines.

We get leaves from the trees (women laugh). Sometimes we just rub it on the children when they are sick. We just make an ointment with the oil and leaves. We don’t use baby oil, we use coconut oil. Sometimes when the children get a fever, we don’t give them medicine [Western medicine]. We just give them Chuukese medicine. Sometimes we can tell when the Chuukese medicine will cure it.

As for me, I don’t use Chuukese medicine. But I know that the Chuukese that do use Chuukese medicines will go to the hospital and when they are not healed, then they would try to use Chuukese medicine.

When we go to the hospital and our illnesses are not cured or healed then we would use our Chuukese medicine. It is a gift passed down from the elders. They can just see what the problem is and know what type of Chuukese medicine to use to cure the illnesses.

I’ve had kids that have had to break and reset a bone because they waited a week and they are trying to repair the damage by massage. They call in a massage person to massage it back into place. I’ve had a child with a femur fracture where the kid ended up in traction. He didn’t come to school for a few days. And the principal and I went to find him. We drove out into the community to look for the family. We found him, and his right thigh was twice as large as the left. And I said OK, if you don’t get him into the hospital in the next hour I’m just going to call Child Protective Services and they’ll take him. He had fallen out of a tree and landed across a root and broke his femur. And so, and he was lying on the floor, he was completely naked, he was urinating while lying down. He couldn’t get up. I went to the house, I said you’ve got one hour. And I told my boss they’re going to have to take him to surgery and reset the bone. He ended up in the hospital for a month. And the whole thing was: Why didn’t you take him? I didn’t have a ride and I didn’t have money for the hospital, so they were massaging it. And he ended up in the hospital. Key informant (K2)
They don’t have health insurance so they would try Chuukese medicine, herbs, and other means before they come in to the clinic. Sometimes they do come in before using Chuukese medicine. But for those that use Chuukese medicine first, sometimes the Chuukese medicine doesn’t work. So that’s when they come in; sometimes their condition is already worse. K5

<table>
<thead>
<tr>
<th>Use of traditional Chuukese Medicine</th>
<th>Social and Cultural Factors Influence Health-seeking Behaviors</th>
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It goes along with dollar signs and prioritizing. Sometimes making the truck payment is more important than buying the medicine. And then a lot of times, my Chuukese families try and do their natural remedies, herbal remedies, cultural remedies, first before going to seek Western medicine. And sometimes it works, and sometimes it just made it worse because then they have waited too long.K2

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<tr>
<th>Lack of Preventive Care</th>
</tr>
</thead>
</table>

I never go to seek health care for myself.

I, myself, have some health problems. But I don’t go to clinics. I do take my kids to the clinic but I don’t go for myself. I do feel ill and sick sometimes but I never go for checkups.

We will go to the clinic sometimes when we get sick or have health problems. Sometimes we see on the media or in the newspaper what health services are offered to the public and we would attend as well.

I go to the clinic for my kids to get their shots. And I go to the clinic for checkups, like a prenatal checkup.

There is nothing for me to go to the clinic for because I don’t see the doctor and I don’t need to go to the doctor. The last time they came here [during an outreach to the village] to check, that was the time I realized I have a sickness. It is hard for me to go down there to the clinic. I went down there to the clinic and tried to make my appointment so that I can see the doctor and I just took off. I left because the lady just told me you cannot make an appointment now because it is already full. Until now I did not go back and this was ever since last year.
Um, [long pause], it’s just that in women’s health and family planning, it’s not very busy. We don’t really see a lot of Chuukese women come in for family planning and women’s health. I don’t know why. They do come in for prenatal care when they are pregnant. Some do, some don’t come in for prenatal care. But only if they’re pregnant do they come in. But in terms of family planning and women’s health, you don’t really see that many of them. But maybe that’s something we need to target with the population. But before we do that, we need to find out if that’s something that they would do, something they would be interested in. We do see a lot of Chuukese bring their children in for child health concerns, but not women’s health in terms of family planning. And so for family planning and women’s health, Pap smears, sometimes they don’t understand. I mean we have to spell it out. And so, for things like that they need more education. And you can conclude that they do need a lot of orientation in terms of their health and then the more we teach them, the more it will help. It will help everyone else who is involved in their care. Key informant (K5)

Even though they want to have someone translate, some Chuukese don’t want other Chuukese to know their problems. It is important to have what you are doing right now, going around educating. But we need help with translators so the people could better understand the importance of health care. But the problem is the possible leak of information of confidential health problems by the translators.

But with the health problems the translator would find out people’s illnesses and sickness. Then they would go tell others about their health problems and people would not want to come for checkups

I want a translator, but if I can’t trust them, I won’t go. Another participant stated, “We cannot express everything [to a Chuukese translator].”

It has to be someone I can trust, like an older lady, or someone from the church. I don’t know about the younger generation, if I can trust them. It has to be someone I trust.

They keep things to themselves. It’s easier to talk to an outsider. Do you know why? They never told you? Because if I know you or you know me, and we start talking, and I find out things about you, then I’ll be able to go talk about you. That’s what they don’t like. Yeah, but a stranger—they don’t care, because that stranger’s not going to talk
about them to the people they know. Key informant (K3)

You need to make them understand that if that person is hired to be a translator, they have to sign an oath of confidentiality. That’s very true. So that’s why, when they come here, there’s some of them who are withdrawn because I’m a Chuukese. So I have to be flexible, I have to show them that in order for them to have confidence in me, they have to know that this is my job and I can get fired if I don’t maintain confidentiality. We need to explain to them because in Chuuk, we have no confidentiality. In our small island everyone knows everybody’s business. No matter what, there is no confidentiality. When we’re in Guam, our story today can stretch and it’s already in Chuuk, it’s faster than the airplane. Key informant (K7)

There was one time that I went down to Court, and there was this lady from Polowat [a Chuukese island], I thought she was a social worker, but she’s in the juvenile section. And they sent her to me to be my translator. She came out and she was introducing herself. I said, “You’re from Chuuk, I don’t need a translator.” I said, “Do you mind? You are Chuukese, I’m Chuukese and we both are English speakers. If they’re giving you to me because they think I’m Chuukese and they think I don’t understand the language, then I don’t need your help because I speak English.” I requested for someone else to assist with the situation. And she had to explain to me saying, “I know where you’re coming from.” And that’s how we think automatically, but I know better. She was very helpful and I really appreciated her, even though I rejected her at first. She was very much understanding and had compassion for how I felt. She explained that she knows she is supposed to keep everything confidential. She even said, “Even my spouse, I don’t share anything with him.” Key informant (K7)

They’re so mean, the health workers in the clinic. The health workers are very mean. When I took my mom and dad to the clinic they were so mean and not very helpful. They were taking their time.

Some Chuukese won’t go to the clinic because they’re scared. Just like me, when I go to the clinic I am scared to look at their faces.

My food stamps application was held up for 7 months. Then my sister came with me to help because she speaks more English. We went to the head of the food stamp section
and called the case worker. My sister asked to see a supervisor. Then they found my application and processed it right away.

It also took a year to get my food stamps processed. My case worker took my application, put it under the rest and never worked on it. The next time I came I told another lady about it. She asked me how long it had been since I turned in the application. I said 1 year. She said we're going to meet the supervisor. And just that day she helped me. They pulled out my application. They had looked for it but couldn’t find it. They found out that the case worker stored it in her files and did nothing about it. The supervisor then pulled out my application and that day they processed it. They told me just this evening that I can use it.

Two weeks ago I went to public health. I applied for food stamps, gas, MIP and Medicaid for my daughter. One of the case workers was no good. And I just took the paper and I said, “Why you don't respect me? Why do you ask a lot of questions? You told me first that I can apply for MIP.” I told her to just give me the application and I threw it away. And I just walked out.

The case worker then asked me to give her my passport and then said that I am not eligible. I had to come back after 6 months. Then I asked her why she had to ask a lot of questions before, when now you just told me to come back after 6 months. But yes, I did check up on those things in my application.

Sometimes I say to the women “Let's not use our skirt so they won't know we're Chuukese.” Sometimes I go out, I wear pants so they don't know I'm Chuukese.

Yes. Yes. I have, I have. They have come to me and told me the stories that they went to the hospital and they were sent home. And I’ll ask them, “With this? They sent you home with this? Why didn’t they do this? Why didn’t they do that?” And so it’s, for me, as a practitioner, I have to, in my mind, make sure that I’m not doing that. That I’m not looking at them as a Chuukese person, but unfortunately sometimes I have to look at them as a Chuukese person, because culturally, I have to accommodate their culture. But then I also have to educate them that they are in Western culture now and that is not how it’s done here. There are some things that you have to adapt and change. And health care is one of those sticky areas with them. Key informant (K2)
So, you can sense it when you walk in to the clinic. You see that it’s all Chuukese people in the waiting area; and then you can see that whoever is the intake person or the clerk, you can see that they are not being friendly. When someone from a different culture walks up to them, they react differently. When a Chuukese person walks up to them they are treated differently. I see it, and I’m uncomfortable when I see that. They are marginalized. Key informant (K3)

I do feel that I am treated differently. I come across people that will talk like they know I’m Chuukese, but they don’t know I understand Chamorro. A couple years back, in the 90s, I brought my ex-husband’s uncle to the clinic and this lady will never forget me. There were a couple of them in the receptionist area. I went in and this lady said, in Chamorro, “Ai, this lady, she thinks she can bring all her family.” So I turned around and I said, “Excuse me, First of all, I am Chuukese, but I am also part Chamorro, and I very much understand every word you said, and second of all, that’s why you are working here, and if we are qualified, then why not?” Boy, she disappeared. Key informant (K7)

There is a lot of discrimination, even at the clinic and at the hospital, there’s a very big problem there. We have concerns at the hospital and we’re scared. We don’t know where to go. We’re scared to voice out what we want to say. We cannot voice our concerns. The main concern is at the hospital. I would prefer if there is an investigation into the number of Chuukese deaths. If I look at the number of deaths and I compare the different nationalities, what would it be for the Chuukese? But the Chuukese, every week there are deaths. I’m not talking about accidents or suicides; but those who go to the hospital for other diseases. We feel like we are treated differently. We’re not being treated like we’re supposed to be treated. We don’t deserve to be treated poorly. Key informant (K6)

They took good care of him at rehab. They even helped my mom by telling her to rest. They kept him clean. They really understand the Chuukese over there. I think one of their staff is married to a Chuukese man. They were really nice to us and took good care of my father. But at the hospital, they don’t take good care of the Chuukese. They don’t like the Chuukese there.

I notice that that’s why it is always the women that are coming to us. When I say, “Where’s your husband? Is he sitting in the car?” And I tell them, “Go get him.” The women are the gophers. The man will sit there in the car and send the wife in. I drill the
husbands. “Why is it you are sitting there and your wife is coming in here?” And I really get on them. I always feel comfortable with those kinds of things. I don’t let the culture intimidate me. I guess the men don’t mind because they sense that I am not really putting them down. I care, that’s why I’m attacking them. They know that I care about them. When I attack the husbands, the wife will be there smiling. It’s really funny sometimes. And they really like it when I scold the husbands. Key informant (K3)

You know what, those women that speak out, they’ve gone through education. It is very common in a lot of Chuukese families, that they’re using their daughters and their sons, mostly their daughters because those men, they’re higher than us ladies. So we tend to do everything for the family. Those men, they bring their daughters for things like translating. And because the daughters are more exposed to the system, and more educated, they’re not afraid. Not like the Chuukese that just migrated to Guam, or the ones that are not exposed to the system at all. That’s why you’re noticing that. But I guess, when they stay longer here also, they will be exposed and experienced. And in time, they will know what to do, even if they don’t have formal education, or very little education. They will be able to fill out their public health application and all the papers. They will be able to get in and out, in and out. So they will be able to say, “Ok, so I can do it.” Key informant (K7)

With the school, you know, like I said before, the Chuukese men, the men are considered superior. We respect them. But the Chuukese men, when they go to the school, the workers sometimes treat them poorly. The Chuukese men don’t really feel like they’re treated according to the Chuukese culture. They are treated like… (mimics yelling). But us Chuukese women, we cannot yell at the men. We cannot raise our voice. We have to be (speaks softly) like our tone of voice, we cannot be like: “Well, sir” (speaking loudly) But the workers in the schools should understand the cultures. Key informant (K6)

I think that for the Chuukese men, it doesn’t really matter. Some of the men may not feel comfortable with a female health care worker. But it’s not as bad for the men as it is for the women. Because the men in Chuuk, they can shower together in the stream, naked, it’s no problem. But for us, even in a group with all women, we cannot be naked. For females, we consider the area down here as private [points to groin and legs] but not up here [pointing to breast area]. When we go to the stream to bathe, even if we are all
women, we cannot just wear our underwear. It may not be a problem for the young girls, but for women my age, especially if there are older women such as our elders present, we cannot just wear our underwear because it is disrespectful. We should not show our private areas to others. We have to cover our lower body with clothes. It is worse for women. For the men, it is OK for them to show their bodies. Key informant (K6)

If it’s not a Chuukese male there is a difference. It’s funny; I’m going to explain this. The Chuukese men, from my experience, if they see your private parts, they’re going to announce it. You know, if they see your private area they’ll say this and that, you know. So it’s just that the Chuukese women don’t want to be embarrassed. They don’t want Chuukese men to see them. She may not want that person to see her or he’s going to go around and say, I saw this. But yes, if the doctor or worker is from a different nationality he’s fine. Key informant (K6)

I went to Chuuk right after graduation. I already preregistered at the university. I went to Chuuk, and the only thing that was pending for me to have at the university was the physical. When I went back to Chuuk, they said you can have this even in Chuuk, as long as it’s a doctor; it’s signed by a doctor. So I went to the hospital and asked who can perform my physical exam. And they said doctor X [Chuukese male doctor]. I asked, “It cannot be a woman?” You know, at that time I was still a virgin. I said “That guys going to see my private area? He’s not even my husband.” I said “Forget it.” And I never came back. I said “No, no he’s going to see my private areas.” Every time he sees me he’s going to laugh at me because he saw my private area. That’s our mentality because that’s what’s happening. That’s what the men do, because of the fact that they’re higher than us women. You know in Chuuk, they can rape us; they can do whatever they want. They can touch us. There’s no law that can protect us women. In Chuuk, no way, the men, that’s why they’re allowed to do anything. That’s why they can even have two wives. They’re dominant and that’s why they step all over us. They can have you sexually and then they go out and announce it to their men friends. Key informant (K7)

Now, they go into other programs in the clinic, the workers talk to them, or tell them what to do. But the way they talk to them is bad because they’re specifically from the islands, they’re from Chuuk. Now, the women would talk back, and they would argue back. The women are becoming more assertive. They know they’re right, and more so,
they are standing up for the rights of their children that they’re representing. So it’s true, and I’ve seen it, and here in the clinic, in particular, because that’s where I observe them. But it happens not only in the clinic, but other areas and programs in the center. I can say that the Chuukese women are getting better in responding to those people who are putting them in that position. They respond to those people treating them badly. So, there’s some improvement. Key informant (K5)

Again, they will not go to the clinics because of transportation problems (tapping hand on desk to emphasize). They will not seek assistance because they cannot communicate effectively in English. But again, if they are educated, they can communicate in this modern language of English. And I would say, the more they are educated (pausing) let’s go back again: Education means getting a job. Education means getting a job (repeated). Education means getting transportation. So, they are going to the hospital, but if they cannot get a job, or get educated, they would be stuck for a long time. So I would say the problem is lack of education. And the solution is (pausing for emphasis), help them to be educated. Key informant (K1)

You know, my perspective is this: I have seen Chuukese women who are educated; not all of them. But I believe that it is more likely that the more educated they are, the better health they have. So education has so much to do with better health. So, the less educated they are, the more difficulty they would have. Key informant (K1)

And then another thing is they don’t really know where to go, or the routine or when to come in. They don’t come in because they need a routine health maintenance appointment. They come in because it’s already too late, they already have a problem. One of the problems is they don’t remember to come in for their regular checkup. They don’t come in until they have a problem and then they can’t deal with it. Key informant (K7)

Their diet for one. They are lacking in the knowledge of what makes up good health. They need health education about nutrition in a language that they understand. Education about diet because they eat whatever they can afford, if it’s something that’s not good for them, or if it’s good for them, you know, they have to eat, so they eat. They buy because they can afford it, and that’s what’s available, so they eat it. They don’t really have a lot of knowledge as to what’s good for them. They don’t know what kind of food is good for
them, what kind of food is not good for them. Sometimes they hear a lot of things, but it’s in English, so they don’t really understand. And sometimes they hear it from other patients. So, when you sit down and talk to them, you find out that they don’t understand what kind of food they need to eat in order to maintain their health and what kind of food they need to avoid if they have hypertension and diabetes, and other problems. But, not until you sit down with them do you find out what they know. So, a majority of the time, it’s lack of knowledge, education related to diet and chronic disease prevention, and health maintenance. Key informant (K5)

But I can say that ever since I’ve been working in Agency Y, I can say that women, Chuukese women, have improved. They have come a long way, and they have shown that they think about their health. They take it very seriously. You can see that they’re taking better care of themselves by coming to the clinic and coming for follow-up care. You know, you can tell that they’re taking their medicines, things like that. So there are some improvements, but they still need to be routinely oriented to the health care system. They need to be provided with health education again and again. Key informant (K5)

They don’t really understand the difference between the hospital and the clinics. They think that because they’ve been to the hospital before, they always go to the hospital for any type of care. Especially for newcomers in Guam, they think the hospital is where to go, like Chuuk hospital. We go there for anything pertaining to health care. The Chuukese don’t know about public health clinics. They need to make the Chuukese understand when to go to the hospital and when to go to the clinic. When the Chuukese go to the hospital, they don’t always get what they really need. And if the problem is minor, they charge them a lot. It is better to educate the Chuukese and tell them to come to public health centers rather than going to the hospital. They can come to the clinic for evaluation. They can refer them to the hospital from here if needed. Then they will pay less. That’s the problem now, some patients are sent to a collection agency for unpaid bills. They’re going after them. But you know it’s not that it’s because they want to go there, but they don’t understand the difference between public health centers and the hospital. Key informant (K6)

Why not educate patients from the Federated States of Micronesia before they leave and relocate here? Why can’t you educate them before they get here? There should be some
sort of training, in-service or workshop before they leave the island so they know what to do before they get here. Key informant (K4)

I think that it would be helpful for the Chuukese community also to educate their migrants before they came here, or to make some kind of requirement of a class, or something so that they better understand how the system works here. They come to me with family and the family tries to take care of them, but they have no concept of how the system works here. So, if you don’t have a family member here that speaks English well and knows the system well, they fall through the cracks and then they’re just trying to hide. You know they’ll come to school and their shots are not done. So I spend months following up making sure their shots are done. They’ve been here for a few years, but because they don’t know the system, they’ve just ignored the requirements and so they’re behind. Key informant (K2)

Maybe immigration should have a list of what they need before they move. They should give them a list at immigration because that is where they apply for a passport. Maybe give them a list when they apply for a passport so it will be easier before they move. This would help for those moving here to Guam, and to other places. There should be a list that tells them what to bring such as a birth certificate, because offices here, like the Guam Housing and Urban Renewal Authority for housing, and to apply for food stamps, they need a birth certificate. And of course, at the clinic, they will need their health record including immunizations. For FSM citizens, you need a passport. Just give them a list, and they will obtain the required documents while the passport is being processed. And their life will be easier when they come. Key informant (K6)

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<th>Significant Statements</th>
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<td>Yes, for all of these things we’ve been talking about like the poor treatment, the attitude, the problems we face trying to get medicine, and the problems with the lack of health insurance. Or the problems for those that have insurance such as Medicaid and MIP. So by our meeting with you, would you be able to help improve or find solutions to these issues?</td>
<td>Political Influences Affecting Migrants</td>
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<td>Yes, this is very important that you know of the issues we face with the health care system in Guam and help the Chuukese population in seeking health care, insurance and in getting help from other health departments.</td>
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I think it has to be done ASAP. Because the longer we wait, it’s going to affect the economy. When people are healthy we don’t spend that much money, but when serious things happen, we spend a lot of money at the hospital. A simple boil can turn into something more serious down the road. K3

If we start out with the opinion that, well they should get a better job, so that way, the company that they’re working for can cover their health insurance. And another issue is that the system is just getting worse financially. You know, it’s the money. The money is getting less. I guess that’s where the Compact of Free Association comes in. They should have looked at it this way. Now that we can really move around in the States then let’s look at that. What if our people move out, and they make a living here in Guam, Hawaii, or in the States, then what can we do for them? Money has a lot to do with people’s lives. I guess that our homeland can probably help us. Right now, Guam is complaining because they’re not receiving enough money from the Compact Impact. That’s one thing to do, if you want to be here, then, you have to have some kind of plan. You know, how you are going to survive and how you are going to take care of your health are important issues to think about and plan for. Key informant (K7)

And because a lot of them have just arrived on the island before they come and seek medical attention, they’re not eligible to receive MIP until after 6 months. The private entities don’t take self-pay so they end up here for dialysis. So they’re stuck, they can’t go back home to Chuuk. They have to find a way to relocate here or go to another island. But even Pohnpei has only two machines, but they’re very limited. In fact I have one Pohnpeian patient that was told there was no space for him to get dialysis in Pohnpei; you have to go off-island. So she ended up here, eventually she will be applying for MIP assistance. And if you look at the bigger picture, that’s why we’re suffering here at the hospital. Key informant (K4)

I believe that the migrants, especially citizens from the Freely Associated States (FAS) should come here for education and employment opportunities. They should not come here just to live off the welfare system. Yes, if they come here for school and need the temporary assistance, then of course, they should receive assistance. But to come here and be dependent, that’s wrong. Key informant (K3)

I know some of these people, once they come from Chuuk; they think Guam is like Chuuk. But it is not. They have to pay rent, water, sewer, electricity, and things like that. I came from an island where there is no electricity, no inside plumbing. But they have to learn that it is different here. They cannot blame the government of Guam. Key informant (K1)

I think with what’s happening now, because of the economy, we are going to see that a lot of the migrants now, especially the Chuukese community; they might get a little skeptical about being interviewed. Because they might feel like everyone out there interviewing them is trying to send them home. Especially now with our own Counsel General
saying the FSM citizens are breaking the law if they are receiving food stamps. This was just in the paper recently. I
don’t know if it is really a problem, but it is scaring the migrants. So those in the FAS community are kind of skeptical
about whoever is out there asking them questions. People are starting to be cautious. Key informant (K3)

It’s kind of sad because, you know, the U.S. opened up this migration opportunity and then it seems like now, from my
own observation, they’re starting to monitor it. Maybe they are trying to control the number of people coming in, instead
of finding other solutions. Is the migration really the problem? When you compare it to other migrants, is the effect from
the FAS citizens that much greater? I don’t know. That’s why I’m concerned. The Federal government opened this up,
and now everyone is scared of these small nations of the FAS, when I think there are bigger, larger migrant problems.
Key informant (K3)