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Postcolonialism and the Marshallese Diaspora: Structural Violence and Health in the Marshallese Community in Springdale, Arkansas

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**Postcolonialism and the Marshallese Diaspora: Structural Violence and Health in
the Marshallese Community in Springdale, Arkansas**

In Partial Fulfillment of the Requirements for the Degree

MASTER OF ARTS

in

INTERNATIONAL STUDIES

by

Alexander James Hirata

December 1, 2014

UNIVERSITY OF SAN FRANCISCO

Under the guidance and approval of the committee, and approval by all the members, this thesis project has been accepted in partial fulfillment of the requirements for the degree.

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Abstract

Despite moving to the United States for better healthcare, among other benefits, Marshallese Compact of Free Association (COFA) migrants residing in Springdale, Arkansas continue to face similar acute health problems as Marshallese living in the Republic of the Marshall Islands (RMI), and often without access to health services. These problems include high rates of noncommunicable diseases, such as type 2 diabetes and thyroid cancer, as well as rare conditions such as Hansen's Disease.

To research this, I studied the limited texts surrounding the Marshallese diaspora, as well as relevant bodies of literature: postcolonialism, Pacific migration theory, and global health and structural violence. I also conducted topical interviews with Marshallese and non-Marshallese community members, health workers, and government officials in Springdale, Arkansas.

The two biggest barriers to healthcare in the Springdale Marshallese community are poverty and a lack of health insurance. These and the Springdale Marshallese' biggest health problems can be traced to the structural violence caused by the continuing colonial relationship between the United States (US) and the RMI. Many existing health conditions carried over from the RMI are a result of the poverty, slum conditions, displacement, and irradiation present there, all of which can be traced back to US military occupation and intervention. Current US social services laws have stripped COFA migrants of the publicly funded health benefits (e.g., Medicaid) they were promised in the original COFA. While Marshallese COFA migrants are eligible for subsidized health insurance plans offered by the Affordable Care Act (ACA) of 2010, the Marshallese

community's low income qualifies them for the health plan bracket reserved for the poorest: Medicaid expansion. Due to their COFA migrant status, however, they are ineligible for Medicaid in Arkansas. Practically, the ACA does little for Marshallese COFA migrants living in Springdale, of which even those with health insurance struggle to afford healthcare.

I recommend reinstating federally-funded social services such as Medicaid and the Department of Agriculture's Supplemental Nutrition Assistance Program to COFA migrants, as this was prematurely removed from the first Compact between the US and the RMI to the continuing detriment of Marshallese COFA migrants in the US.

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I also thank Canvasback Missions, which allowed me to apply what I learned and wrote about in school to real-world projects with the Marshallese and which flew me to the Marshall Islands to work. Canvasback also allowed me the time off to conduct research in Hawaii and Arkansas.

Lastly, I would like to thank Calvin, who contacted me while I was in California and made himself an invaluable contact, resource, and connection to others during my research in Arkansas. All of this, despite never having met me and assuming that when we met, he would see that I "would be old, fat, with no hair."

Chapter 1

Introduction

The town of Springdale, Arkansas in the United States of America (US) has the first or second largest population of Marshallese outside of the Republic of the Marshall Islands (RMI).¹ The US and the RMI have a special agreement, called the Compact of Free Association (COFA), which gives both countries special privileges in the other. The US gets exclusive military access to Marshallese islands and ocean, and the RMI receives monetary aid, permission to use US currency, and valuable visa-free travel and work privileges within the US. Marshallese COFA migrants move to Springdale for higher paying jobs, quality education, and better healthcare. In addition to employment, health, and education, Springdale offers Marshallese COFA migrants a significant Marshallese community, which eases transition into the States. Churches, relatives, and free housing with family are easy to find in Springdale, where the Marshallese community remains close and familial.

Migration to the States is an increasingly attractive prospect, as the RMI continues to face health and economic problems. The RMI has the world's third highest prevalence of diabetes as well as low life expectancy and high rates of cancer, among other issues. It has few hospitals and medical professionals to address these problems. The Marshallese economy suffers from distant isolation from other countries, a lack of natural resources, little land, and susceptibility to its environment (e.g. typhoons, drought, high tides, salt spray injurious to agriculture and infrastructure).

¹ Census data on Marshallese in the US is inaccurate and unreliable. Either Hawaii or Arkansas has the largest population.

Despite moving to Springdale to access better health services, the Marshallese community there remains in poor health and frequently does not have available healthcare. My primary research question is, what are the social determinants of health acting on the Marshallese? And what correlation, if any, do they have with the ongoing colonial relationship between the RMI and the US? I examine the Marshallese diaspora from both a macrostructural perspective, looking at the relationship between the US and the RMI, and at a community level, examining the dynamics of Springdale. I argue that the contentious and continuing colonial relationship between the United States of America and the Republic of the Marshall Islands is both boon and bane for Marshallese COFA migrants. On the one hand, it provides significant financial aid to the RMI while also providing invaluable work and travel privileges for Marshallese COFA migrants. On the other hand, it maintains a structural violence over Marshallese, largely stemming from neoliberal notions of welfare, that causes health and economic problems for Marshallese in the RMI and in Springdale.

In order to answer my research questions, I draw upon three bodies of literature: postcolonialism, Pacific migration theory, and global health and structural violence. Postcolonial literature provides the language to assess and label the relationship between the Marshall Islands and the United States. Despite not occupying the RMI for its natural resources, the US continues to have a colonial relationship with the RMI. In the past, the US abused the Marshall Islands' land and people through nuclear weapons tests and displacement, and it currently maintains its relationship with the RMI in order to secure strategic military dominance over the Pacific Ocean.

Migration theories provide insight into possible push and pull factors for migration, ranging from economic prospects to social capital. While no single theory can explain the Marshallese diaspora, pieces of each are relevant and helpful in understanding motives for migration. In particular, Bourdieu's idea of social capital is helpful in understanding why there is such a large concentration of Marshallese in Springdale, and it touches on economics, religion, convenience, and family.

I chose to look at global health, since the discipline takes a holistic and multidisciplinary approach to understanding population health. The lens of global health conveniently allows me to understand migration and the lingering effects of colonialism (i.e., law and policy) on a population's health. Global health also addresses structural violence, which, along with the Compact of Free Association, is key to understanding the health of the Marshallese diaspora in Springdale.

Using these three bodies of literature, I frame the US-RMI relationship as a historical and contemporary form of colonialism. The effects of US intervention in and occupation of the Marshall Islands created—through displacement and overcrowding, irradiation, and disruption of natural diet—many of the health problems faced there. These health problems, in turn, are part of the many push factors maintaining the steady migration from the RMI to the US. Once in the US, Marshallese COFA migrants continue to face the aftereffects of colonialism, as the COFA that emerged from the US-RMI relationship has a strong effect on their ability to get publicly funded healthcare. The COFA, along with the health and economic conditions in the RMI, are all part of the structural violence maintained by the US over the Marshallese.

Methods

In order to answer my research questions, I combined practical and theoretical research. This means I collected new data and drew from existing published texts. I used both qualitative and archival research, and I committed to a theoretical application—sifting through and interpreting data—once I finished collecting data.

My archival research included studying existing texts related to my topic of study. I visited libraries, including University of Hawaii's Hawaiian and Pacific Literature Collection, the largest of its type in the world. I also mined news sources and government statistics and reports. Since academic texts on the Marshall Islands and Marshallese COFA migrants are relatively scarce, I relied on networking and referrals to find the authors and texts I needed.

My qualitative research began with informal interviews with professors at University of Hawaii during a week-long research layover on my flight from Majuro, Marshall Islands to California. Later, I spent two weeks in Springdale, Arkansas, where I held nine formal topical interviews with nurses, the Springdale mayor, the Consul General of the RMI Consulate in Springdale, the Director of Research at University of Arkansas for Medical Sciences, Marshallese employees in Springdale, advocates for Marshallese in Springdale, and other Marshallese community members. I held several other informal interviews with Marshallese and non-Marshallese there and also attended funerals, church services, meals, errands, and celebrations with Marshallese community members. I used the snowball method, my primary contact, and personal research to find contacts to interview and work with in Springdale. Most interviews were an hour long,

and topics discussed included patterns of and reasons for migration, community integration, employment, health, and other relevant topics to Marshallese in Springdale. In this thesis, the true names of most interviewees are withheld in order to ensure confidentiality.

Contribution to the Literature

This research has the potential to contribute to the small body of literature that exists around and about the Marshall Islands. This research does not add to the deficit of hard data and statistics concerning Marshallese in Springdale, but it does rely heavily on the opinions of the Marshallese themselves. I find this important, since few Marshallese author academic texts. There are academic discussions of other Marshallese communities in the US (Orange County, California; Enid, Oklahoma; Kona, Hawaii) but no theoretical texts on the population in Springdale, Arkansas. There is, however, plenty of local news coverage, a few health and immigrant survey reports, and general public awareness of the Marshallese population there. Creating a narrative of postcolonial structural violence will, hopefully, further two things: an understanding of the systems of power that cause the Marshallese diaspora and an avenue by which to address the structures that affect Marshallese health. Also, despite its long history with the United States and its housing of an invaluable missile base, the Marshall Islands is largely out of sight and out of mind of US politics, academics, and citizens.

How this Thesis is Laid Out

This thesis is structured as follows. The second half of this introduction contains the context necessary to understand the Marshallese diaspora in Springdale. This includes

a brief history of the Marshall Islands-United States relationship, which sets up the beginning of next chapter's review of postcolonial studies. Also included in this are some of the international and domestic patterns of Marshallese migration, as well as some of the major reasons for migration.

In the next chapter (Chapter 2), I review three bodies of literature that form the foundation of my argument. These are postcolonial studies, Pacific migration theory, and global health and structural violence. I review the major authors and ideas in each of these and explain how each is useful in interpreting my data. Combined, these theories provide the tools for uncovering a narrative that supports my argument.

Chapter 3 is my data analysis. In this chapter, I interpret data from my research and interviews through the literature to provide a cohesive narrative for the Marshallese diaspora. I cover the Compact of Free Association, detailing its history and benefits for the US and the RMI. I also discuss the unique migrant status that the COFA provides for Marshallese who move to the US. I address the problem of health insurance in Springdale, which largely affects those with COFA migrant status. Then I look at health as a reason for migration, as well as the patterns of and barriers to health in the Springdale Marshallese population.

The last chapter is my conclusion, which summarizes my findings and has my recommendations on possible actions or areas for further study. It also links this study to the broader discussion on immigrants and migration studies, analyzes the significance of my findings, and presents questions raised by this research.

*History of the Marshall Islands-United States Relationship in the Pacific*²

There are certain contextual items that are important to know for this thesis. For example, since I argue that the colonial history between the US and the RMI has an impact on the current state of health of Springdale Marshallese, it is important to have a brief background on the relationship between these two states. This not only gives basic context, but also shows the indirect creation of acute health problems in the Marshalls. Also important is an understanding of the basic patterns of migration to the states. These provide an understanding of some of the dynamics characteristic of Marshallese migration, such as the fluidity of family or the trend in leaving Arkansas for Washington and California when older in order to receive Medicaid. Also, I give a brief summary of the reasons Springdale has become such a popular destination for Marshallese COFA migrants. Here, I will provide a brief overview of the Marshall Islands. I will also give a brief history of how US militarization created overcrowding and health problems in the Marshall Islands, using the island of Ebeye—the second largest population center in the RMI—as an example.

Ebeye is a small islet in Kwajalein Atoll, which is the largest atoll in the Republic of the Marshall Islands. Atolls are rings, or chains, of small coral islands placed around a lagoon (Murphy 1950, 59). The RMI is a sovereign nation in the north Pacific Ocean. It is commonly categorized as a small island developing state (SIDS), a term used to refer to island nations with few natural resources, small export economies, and high dependency

² Portions of the sections *History of the Marshall Islands-United States Relationship in the Pacific*, *How US Military Occupation Altered Health in the Marshalls*, and *Ebeye's Lifestyle Health Problems* are adapted from unpublished content I wrote for a paper submitted for a class at USF in Fall 2014. See (Hirata 2014).

on imported goods. During World War II, the Marshall Islands was considered a strategic location in the bloody Pacific theater, and it saw much fighting between the US and Japan. Immediately following World War II, the Marshall Islands was placed under United States control by the United Nations as a Trust Territory of the Pacific. The purpose of this was for the United States to provide postwar assistance in order for the Marshall Islands to recover, build a self-sufficient economy, and become independent. The Marshall Islands is no longer a UN Trust Territory under the United States, but it does maintain a special agreement with the United States—a Compact of Free Association (COFA)—which provides both states with certain benefits while allowing the Republic of the Marshall Islands to be an independent and sovereign nation.

How US Military Occupation Altered Health in the Marshalls

One of the US' first actions as the Marshall Islands' trustee was to import food. The war had left Marshallese lands and crops destroyed, so this immediate food aid was essential. However, this initial emergency food aid turned into a steady dependency. Accompanying this modern western food was the need to establish a method of trading these new goods. This is why the Marshall Islands switched from a barter-based economy to a cash-based economy. In addition, the consumption of imported foods removed the need for agricultural labor to grow food crops, ending a major active lifestyle. A recent study of NCDs in the Marshall Islands sums up all of these changes nicely:

Shifts to non-traditional occupations, the development of a cash-based economy, and the availability of imported modern western food have negatively impacted food habits among the residents of the Marshall Islands. The traditional, nutritionally rich diet consisting primarily of breadfruit, coconut, pandanus, taro, fish, chicken, and pork has been replaced by imported, canned, and processed food. Alcohol, smoking, and substance abuse are on the rise particularly among the young. The change

in the way of life in the Marshall Islands that has led to changes in dietary and physical activity behavior, has led to an alarming increase in the prevalence of diabetes and the secondary complications associated with diabetes and other chronic diseases. (Ichiho *et al.* 2013, 78)

The United States' food aid created a series of events that fostered the lifestyle health problems outlined above. As the quote above states, the Marshallese, and especially residents of Ebeye, mostly abandoned their traditional nutritious diet to eat unhealthy food and use unhealthy substances. The US has been shipping food to the Marshall Islands ever since it established a presence there. This dependency on imported foods is a regular part of life, as are the high rates of mortality and morbidity caused by them. It is a structural problem.

The United States also chose another course of action that permanently changed Ebeye. The US military built a base on Kwajalein Island, the largest island in Kwajalein Atoll, and continues to hold that land today. The US managed to hold onto this land after the Marshallese declared independence by forging the COFA. This Compact assured the RMI money and unrestricted travel and work rights for Marshallese in the United States. In return, the US was allowed the continued use of Kwajalein Island as a military base. This base, built during the Cold War, led to the creation of the Ebeye slum.

There are two primary reasons that Ebeye came to be densely populated, and both are a result of the US military. The first mass migration to Kwajalein Island occurred in 1944, after the US defeated Japanese forces on the island. Marshallese workers were recruited to clean up and perform infrastructure repairs following the battle, and they stayed behind after the work was finished (Gorenflo and Levin 1989, 100). Many of these workers originally lived and owned land on Kwajalein (Woodard 2000, 71). Shortly after

this, the Marshallese—including those who owned land on and were natives of the island—were moved from Kwajalein Island to Ebeye, another island in Kwajalein Atoll only four miles from Kwajalein Island. The US set up a missile base on Kwajalein that continues to operate today. The second reason for Ebeye’s high population density is the steady migration of Marshallese to Ebeye from other atolls and islands in hopes of working on Kwajalein (Gorenflo and Levin 1989, 115). Jobs on Kwajalein are desirable, as working for the US military is profitable and secure. Yet only about 1,000 Marshallese work on Kwajalein Island, commuting from Ebeye to the US military base by ferry every day (Lopez 2011, 41). The island serves as a “slum-like labor reserve island for Kwajalein Missile Range” (Woodard 2000, 70). Both the initial settlement of Ebeye and the decades of steady migration of hopeful workers were caused by the presence of the United States.

Ebeye has a population of 9,614 people living on only 0.12 square miles of land (Republic of the Marshall Islands 2012, 7). This means its population density is over an astounding 80,000 people per square mile!³ Severe overcrowding, poor infrastructure, unreliable sewage and freshwater systems, high rates of noncommunicable diseases (NCDs), and the inability to grow subsistence agriculture have all earned Ebeye the nickname, “the slum of the Pacific” (*Agence France-Presse* 2010, n. pag.). These conditions—all public health issues—are a result of the US military’s occupation of Kwajalein Island in the Republic of the Marshall Islands.

³ For comparison, New York City—the city with the highest population density in the US—had a population density of 27,000 people per square mile in 2010 (“New York (City) QuickFacts from the US Census Bureau.” 2013, n. pag.). When you take into consideration the fact that New York City is has multi-planar high rise office buildings and apartments, Ebeye’s overcrowding seems even worse; few buildings are over two stories on Ebeye.

Ebeye's most visible problem is its overcrowding. Since this is so apparent, I will begin the list of Ebeye's health problems by naming it a slum, and then listing all of the health problems that mark it as such. When I use the word *slum* in this paper, I use the definition officially used by the United Nations as adapted by Mike Davis (Davis 2007, 23). In *Planet of Slums*, Mike Davis cites the authors of *The Challenge of Slums* as cutting out the social dimension of and presenting the definition of a slum as an area "characterized by overcrowding, poor or informal housing, inadequate access to safe water and sanitation, and insecurity of tenure" (Davis 2007, 22).

A big health problem present in overcrowded slums is clean water and sewage issues. Unfortunately, Ebeye has both of these. In 2006, a 24-hour power generator breakdown caused "sewers to flood, sending excrement flowing into the streets" (*Radio Australia* 2006, n. pag.). The *Agence France-Presse* writes about Ebeye, "the island's sewage system has not worked in five years and raw sewage is being pumped into the lagoon near where children swim" (*Agence France-Presse* 2010, n. pag.). It also wrote: "A US Army report last year said Ebeye's sewage, water and waste management infrastructure was either not working or on the verge of collapse, posing critical health threats to the population of 12,000" (*Agence France-Presse* 2010, n. pag.) It also quotes a US Army report of the state of Ebeye: "'Ebeye's critical utility infrastructure is deteriorated and is unable to sustain the current population'" (*Agence France-Presse* 2010, n. pag.). This US Army report was put together a few years after the Marshall Islands government spent US \$1 million to specifically fix Ebeye's power, water, and sewer problems (*BBC Monitoring International Reports* 2006, n. pag.).

In addition, underground sources of water are extremely limited in all of the Marshall Islands, and Ebeye is no exception; the island is slim, so its small water table is corrupted by salt water from the surrounding ocean (Youngblood Coleman 2012, 163). Many houses and buildings have rain catchments to supplement their water supply, yet Ebeye frequently undergoes periods of drought, making access to drinking water an unsure prospect that forces the island to rely on US Army aid from Kwajalein and aid from other countries (Republic of the Marshall Islands 2012, 23; *TendersInfo News [Mumbai, India]* 2013, n. pag.; Lopez 2011, 40). Because of poor sewage and water sanitation infrastructure and overcrowding, Ebeye has faced disease outbreaks in the past.⁴ Its current condition provides no protection against this happening again, meaning Ebeye residents face a perpetual major health risk

Another health problem Ebeye faces is dangerous informal housing. Spare resources are difficult to come by in the Marshall Islands, as it is costly to import materials. Most of the houses in its two urban centers—Majuro and Ebeye—are built of scrap metal and wood, and it is common for multiple families to live in each house because collecting enough supplies to build a house for each family would be difficult. At the same time, these houses are small and do little to protect residents. The 2011 RMI Census of Housing and Population found that 43% of all occupied homes in the Marshall Islands “were found to be in need of major repairs” (Republic of the Marshall Islands 2011, 21). In Kwajalein Atoll, which includes the US Army base Kwajalein Island as well as Ebeye Island, there were 1,371 occupied houses for a total of 11,408 people in 2011 (Republic of the Marshall Islands 2011, 7, 20). About 1,500 of these are US citizens

⁴ Ebeye experienced a cholera outbreak in 2000 (Beatty *et al.* 2004, 1). Cholera is a bacterial disease that is often spread by infected water sources.

living and working on Kwajalein Island as enlisted members of or as family members of employees of the military. The US citizens on Kwajalein Island live in most of the 580 multi-unit residential houses, meaning most of the remaining 694 single houses are occupied by over 9,500 people on Ebeye. Many families live in each house, and many do not even live in houses. Built of scrap, and each housing multiple families, the housing on Ebeye is poor and informal. The health risks of informal housing include injury and death from fires or collapse (Matheson 2011, 2; Amnesty International 2011, n. pag.; Aurecon 2008, 13). In addition, such housing provides little protection from the elements and against mosquitoes, which are vectors for many tropical diseases.

Ebeye's Lifestyle Health Problems

The residents of Ebeye suffer from major dietary health problems. Due to the occupation by the US following World War II, Ebeye—along with other Pacific Islands—has one of the world's highest rates of noncommunicable diseases in the world (Haberkorn 2007, 105). Unlike the cholera or measles outbreaks in the RMI in 2000 and 2003, respectively (Beatty *et al.* 2004, 1; Hyde *et. al.* 2006, 300), NCDs (e.g., diabetes, hypertension, heart disease) are understood to be lifestyle based (though, of course, lifestyle is not the only determining factor), meaning they are managed and prevented through healthy diet, exercise, and the temperate use of substances such as alcohol and tobacco (Mayer-Foulkes and Pescetto-Villouta 2012, 1). These lifestyle choices, in turn, are often linked to socio-economic status; this is a study in itself, so for the sake of this thesis, a simplified link: lower socio-economic classes are more susceptible to noncommunicable diseases due to less access to healthy food, less knowledge about lifestyle-related diseases, and less access to timely or quality healthcare (Mayer-Foulkes

and Pescetto-Villouta 2012, 2). Exercise is not part of the culture, and adults on Ebeye do little outside of manual labor. A recent pilot project to address the overwhelming prevalence of diabetes on Ebeye even discouraged some forms of exercise: “Jogging or running was not explored, due to the risk of attack by neighborhood dogs and lack of prior coronary artery disease testing in these participants at high risk for cardiovascular events” (Reddy *et al.* 2009, 2). Diabetes, more than any other NCD, is particularly deadly in Ebeye. Currently, it is the second leading cause of death on Ebeye, only surpassed by the category “other” in a recent study (Ichiho *et al.* 2013, 78). Data from a general assessment of NCDs in Ebeye strongly suggest that this is because a “low consumption of fruits and vegetables and lack of physical activity are prevalent” (Ichiho *et al.* 2013, 84). Traditionally (i.e., before “discovery” by outside nations), the Marshallese farmed and fished for their nutritious diet. Since most food is imported now, fresh food is seldom consumed on Ebeye. This is because fresh food is expensive and difficult to ship to the tiny island. In addition, general agriculture is difficult on atolls, particularly small ones: “This general absence of fertile soil, in conjunction with other environmental problems such as inadequate fresh water and excessive salt spray, limits the density and kinds of plant life that atolls can support” (Fosberg and Mason as quoted in Gorenflo and Levin 1989, 119). Ebeye has little free space to grow food, as most stable land is covered in housing. Because of this, residents cannot grow their own natural produce to fight these health problems.

International Patterns of Migration

Migration from the Republic of the Marshall Islands to the United States of America is steadily increasing as Marshallese citizens seek better employment, education,

and health prospects. The RMI has a net migration rate of -4.92 migrants/1,000 population (CIA World Factbook 2014, n. pag.). The two largest communities of Marshallese outside of the RMI are in Hawaii and Arkansas, although there is debate as to which one of these is larger. Official census data on Marshallese populations in the US are unreliable; in Springdale, for instance, some believe the current Marshallese population is actually 2 to 3 times the official figure of 4,300 in 2010 (Jimeno S. 2013, 3).

The first immigrant from the Marshall Islands, John Moody, arrived in Springdale in the 1970s. Recent trends in migration to Springdale picked up around 2000. Serving on the Springdale school board at the time, incumbent Springdale Mayor Doug Sprouse described an “influx of people from the Marshall Islands” at the time.^{5 6} Public health nurse Sadie remembers the increase of Marshallese and other “foreign born” in Northwest Arkansas in 2000 because of its noticeable impact on health: there was a sudden increase in tuberculosis cases. Consul General Carmen Chong-Gum also informed me that 2000 saw the “greatest influx” of Marshallese to Springdale.⁷ She attributes this particular increase to a period of government downsizing in the RMI. As government employees were laid off from the country’s most secure jobs, they and their families moved to the US to find employment.

⁵ Mayor Doug Sprouse, interview with author. September 11, 2014. Transcript.

⁶ Interview is incorporated into the introduction in order to provide necessary context—patterns of and reasons for migration—for understanding my argument. Interview data is necessary here due to the lack of literature on the topic.

⁷ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

During interviews in Springdale, interviewees told me about a migration pattern that isn't listed in any literature on the Marshallese diaspora. Carmen calls it "a season of flying," which was confirmed in my interviews with both Marshallese and non-Marshallese residents of Springdale. Carmen couldn't help but laugh while telling me about this, since it is a peculiarly Marshallese trend in the region. "Income tax season, when people have all this cash with them, then they can help others," she said. "To buy the tickets to come. We seem to have a season of flying."⁸ Aaron confirmed this trend, saying that around this time, "you see a lot of Marshallese at San Francisco airport coming here." Flying family from the Marshall Islands to Springdale is a more sustainable gift than remittances. It allows family to access continuing and better employment, education, and health opportunities rather than cash that will be consumed.

Manuel told me about the season of flying, but he pointed out a dark side to the process that no one else told me. "Some of the family members here in Springdale pay airfare and bring their family members to Springdale to work," he said.⁹ He continued, telling me that some families flew members into Springdale and then used this flight debt as leverage to make new COFA migrants share their paychecks. This was troubling to hear, although no one else mentioned this trend.

Domestic Patterns of Migration

Interviews also revealed certain patterns of US domestic (in-country) migration that are not present in literature on the Marshallese diaspora. Some of these trends are the

⁸ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

⁹ Manuel, interview with author. September 8, 2014. Transcript.

result of cultural notions of family. Others are a result of employment and health factors specific to Arkansas. For many reasons, it is common for Marshallese COFA migrants to live in multiple states throughout the US.

One of the reasons Marshallese move within the US is for family. Manuel has moved five times since coming to the US, each time in order to be with or to improve his own family. Two weeks after I interviewed him, he moved to Wisconsin (for the second time); I helped him pack a U-Haul with furniture from his house and a storage unit before I left. Calvin has repeated requests from his sons and daughter to move to Washington, Nebraska, and Hawaii, where each of them lives. The Marshallese family structure is more fluid than is typical in the US. In the RMI, it is common for children to live with relatives other than their parents in order to be near a school, near better job prospects, or with family who will provide better care for them. Many of the Marshallese I interviewed had older and younger non-immediate family members living in their households.

One reason for housing with non-immediate family was religion. Calvin had his grandson sent to him in Springdale from Hawaii in order to ensure he attended a religious school. Rachel, whom I spent a weekend with but didn't formally interview, had a daughter from her first marriage sent to live with her in Springdale from Texas so that she would attend a church in the same denomination as her.

One of the more unusual reasons for moving within the States was employment. The more obvious trend is moving from one city to another in order to get better or more convenient work. Carmen, for example, ended up in Springdale after the Tyson plant her husband worked for in Missouri shut down, and they moved to Springdale so he could

continue working. But the less obvious trend for domestic migration because of employment is narrow and, perhaps, uniquely Marshallese. When Marshallese who work for Tyson plants are fired, they cannot be rehired at the same plant. They can, however, be hired at a different Tyson plant, as long as it is in a different city. According to three of the Springdale Marshallese I interviewed—two of whom work with Tyson employees—it is common, almost a practice, for Marshallese employees to be fired and rehired. The primary reasons for being fired is for missing work repeatedly, and the reasons for this are varied: drinking, attending Marshallese sports gatherings, attending funerals and weddings, and not worrying too much about work. All of these have in common the trend of “Marshallese time,” which is a self-described attitude of not worrying about timeliness. I discuss that more below, in a section about barriers to integration. Public health nurse Sadie used language to describe the slow trend that I pictured in my head: “They’re just sort of oozing out, little by little,” she said, from the point at which they all enter Arkansas: Springdale.¹⁰ Springdale is the common point of entry for Marshallese COFA migrants moving to Arkansas, and from there they slowly move to neighboring cities as they grow comfortable and as employment or family needs draw them out.

Another interesting—and unpublished—trend in casual domestic Marshallese migration concerns health. This pattern is important to my thesis, as it shows how health needs cause Marshallese to move within the United States. Aaron believes “Arkansas has one of the worst health systems in the US.” As a result, “a lot of our elders are moving out from Springdale because [of] health concerns. They don’t have Medicaid here, so that

¹⁰ Sadie, interview with author. September 11, 2014. Transcript.

is why they're moving to the West coast, like California, Washington state. So they can get those benefits.”¹¹ Older Marshallese COFA migrants in Springdale fall through cracks in Arkansas' health system and are ineligible for Medicare. The oversight in the system is unsurprising: since COFA migrants aren't immigrants, they fill a small and unique non-citizen status that was created by the federal government. Marshallese COFA migrants are also ineligible for Medicaid in Arkansas. In California and Washington, however, COFA migrants are eligible for both of these programs. As a result, older Marshallese often leave Springdale and move to the West coast in order to receive healthcare. Sometimes they move permanently, and sometimes they live there for a few years before returning to Springdale. Aaron said that the higher cost of living is well worth receiving public health care. Calvin, who is 66, lived in Washington for a few months, and spoke longingly of how the state cares for senior Marshallese. Manuel confirmed this pattern as well.

Summary of Reasons for Migration

Marshallese COFA migrants move to the US for many of the reasons immigrants from other areas of the world move there. Through interviews, I found that the primary reason for moving was for employment. There are more jobs in the US than in the RMI, and they are higher paying and more secure. At Tyson Foods and other poultry plants in northwest Arkansas, factory floor jobs are available to those without a high school diploma. These jobs also offer health insurance.

Education was also frequently mentioned. Marshallese COFA migrants arrive in Springdale with hopes that a US education for their children will provide them the means

¹¹ Aaron, interview with author. September 9, 2014. Transcript.

for social mobility. Marshallese children are a significant portion of the school district, with 2,000 Marshallese students in a city of only 77,000 people (Coppock 2014, n. pag.). Education in the Marshall Islands is difficult, where schools are underfunded and children have to live on islands away from their families in order to attend school.

Although not mentioned as a reason for migration, religion appears to be a factor in Marshallese moving to Springdale. There are over 30 Marshallese churches in Springdale, where Marshallese can hold services entirely in their language, wear traditional clothes, and be in a community similar to what they'd find in the Islands.

Lastly, multiple Marshallese said they feel that life in Springdale can be somewhat similar to that in the Marshall Islands. They choose Springdale over other locations because it has plenty of jobs without a busy city feel. And with so many relatives and friends from home there, large parties and celebrations can be held, just like in the Islands.

Chapter 2

Literature Review

Introduction

Three bodies of literature are key to tracing and apprehending the state of health of migrants through the Marshallese diaspora: postcolonial studies, Pacific migration, and global health. In this chapter, I discuss the foundational theorists and their contributions to postcolonial studies, as well as the field's relevancy in naming and understanding the history and current position of the Marshall Islands in relation to the United States and the rest of the world. I name varied immigration theories, including Pacific Islands-specific approaches. Last, I discuss the vogue debate over defining global health, as well as the notion of structural violence, which pairs well with the previous two bodies of literature to create a framework by which to view and understand why the Marshallese migrate to the United States, what their state of health is, and the many determinants for this.

Postcolonial Studies

Postcolonial studies provides an important context and base for understanding the current state of the Marshall Islands and complements the study of Marshallese migration and health. Aimé Césaire's 1955 essay *Discourse on Colonialism* is considered a fundamental text to postcolonial studies. While the US-RMI relationship isn't one of "traditional" colonialism (i.e., the occupation of foreign lands for resource extraction and cheap labor [Fanon 2004, 26]), it is an imperial relationship that can be understood from the perspective of postcolonialism. Césaire presents an equation, "colonization =

thingification” (Césaire 2000, 42), a purposefully simplistic equation which helps to explain certain processes and events in Marshall Islands history that provide context for the country as it is now. Colonization = thingification is the idea that the colonizer must see the colonized subjects as less than human. This thingification changes both the colonizers’ and the colonized subjects’ perspectives of the colonized, making control easier. This idea is echoed by Frantz Fanon, who writes that language is used to distance the colonizer and the colonized, and that it is a purposefully dehumanizing language (Fanon 2004, 15). This process of thingification is what made it okay for the US military to displace the Marshallese Bikinians from their lands in order to test nuclear weapons, dispossessing them of their homes, crops, and burial grounds. The 67 nuclear tests carried out by the US military in the Marshall Islands follows Césaire’s theory that land controlled by colonizers will be spoiled (Césaire 2000). Resources were contaminated, flora and fauna destroyed, islands obliterated, and peoples moved to uninhabitable islands. Again, this process takes place in a nontraditional colonial context; instead of land being despoiled by natural resource extraction driven by capitalist expansion, this land is destroyed by the need for strategic military dominance (via nuclear armament), a tool that protects US capitalistic interests around the world.

Césaire also writes that colonialism disrupts natural economies (Césaire 2000). The concepts of land despoiling and economy disruption are key to understanding the Marshalls. Traditional subsistence agricultural practices, the “old” economy of the Marshall Islands, linger only in the remote outer islands of the country. Fanon writes that colonies quickly become a source of revenue for colonizers by emerging as a new market

(Fanon 2004, 26). Today, the majority of Marshallese depend on expensive imported foods introduced to them by the US military out of need (because of mass displacement and the subsequent inability to gather and grow food) and out of convenience. Most of these foods are heavily processed, as these best survive shipment. This switch not only disadvantages them economically, but it has also led to the high rates of morbidity and mortality from lifestyle-based noncommunicable diseases.

These major social and economic changes forced upon the Marshallese by the US are a form of violence. While the US didn't wage war against the Marshallese, the changes they created had destructive physical and social consequences for the Marshallese. Fanon argues that colonization is inherently violent (Fanon 2004, 1), in part because of the macrostructural effects it has on colonized countries. The idea of structural violence—the indirect social and physical consequences of power inequality—can be seen as an extent of Fanon's theory of colonialism, and this is fleshed out in conversation with Galtung (1969) and Farmer (1999) below. Fanon writes that reparations paid by previous colonizers to previously colonized are deserved payments for histories of violence (Fanon 2004, 59). Ironically, in the case of the Marshall Islands and the United States, significant financial aid and reparations for nuclear testing (a legacy of violence) only furthers the Marshall Islands' financial dependency (a structural violence).

As ideas, communication, and commodities become easier to spread through globalization, the need for new lands and new resources grew. Anibal Quijano linked these two with his concept of the coloniality of power. This coloniality of power is the establishment of modes of power, knowledge, and relationships that emerged from

colonial conquest and continue to survive today. The coloniality of power manifested itself in the world in two primary ways: the construction of race as a means of control and the restructuring of labor and production around capital and the world market (Quijano 2000, 533-534). This codification of races is similar to Césaire's and Fanon's ideas of using language to distance the colonizer and the colonized, but it transcends those notions by claiming they leave isolated incidents in certain countries or regions and become global ideas. These differences in power between specific colonized peoples and their colonizing countries become broader differences in power between certain races. When an idea is no longer regionally grounded, it can become fact around the world. This is what happened with the notion of race, which became associated with color—it has become fact.

Edward Said's concept of Orientalism—that there is a global social binary between the Orient and the Occident, or the East and the West—is similar to Quijano's coloniality of power and Fanon's and Césaire's notions of dehumanizing language (Said 1979, 6). Like Fanon and Césaire, Said provides an understanding for how the colonizer justifies and maintains power over the colonized. Importantly, however, Said's Orientalism takes the concept global, just like the coloniality of power. Coloniality of power and Orientalism span not just space, but time, making it a tool to use in examining continuing differences in power, especially in postcolonial nations today. They don't just relabel the world, they reshape it, too. These ideas are useful in explaining how certain continuing relations between the US and the RMI still happen. For example, the US military's continued occupation of Kwajalein Island, despite the Marshallese' gross

overcrowding on Ebeye Island just a few miles away, can be examined with these concepts. Would the US military do this if the Marshallese were white? If they were US citizens? While the answers to such questions would be speculative, they remain valid questions. They have a purpose: they lead toward uncovering and understanding power dynamics.

Gayatri Spivak contributes to the postcolonial studies by theorizing the nature of the oppressed. She writes of the subaltern (Gramsci 1971), the group kept, via many means, under the hegemonic power. In the context of colonialism and postcolonialism, the subaltern is the group that was or continues to be marginalized by the colonizer. In a foundational essay, she asks if the subaltern can speak (Spivak 1988), if even after supposed liberation from colonial rule the lowest class has a voice. Spivak writes that the identity of the “true” subaltern group is merely difference (Spivak 1988, 80). This notion of difference is similar to Said’s Orientalism and Quijano’s construction of race, though in its simplicity it is a reductionist idea, making it both vague and more flexible in application to various groups of people. This makes it difficult for the subaltern to have power, whether in language, economics, or society. There is room for difference in most social constructions: gender, race, language, etc. Because of this, certain groups are dominant, and others subservient. Not only is class mobility hard for the subaltern, but the colonizer—even after political decolonization—continues to enforce its cultural hegemony on the subaltern. The subaltern is continually created (Spivak 1988, 90), even after the demise of traditional colonies.

Viewing the Marshallese as the subaltern is useful in examining their situation and position. More importantly, understanding the Marshallese as subaltern is a step toward ending their position there. With this context, and with the tools provided by Césaire, Fanon, Said, and Quijano, we can understand the dehumanization and differences in power that created the RMI as it is today.

Pacific Migration Theory

There are no comprehensive theories of migration, *per se*, but multiple theories dealing with various facets of it (e.g., economics, sociology). In this section, I review three broad theories of migration which prime the reader on migration and provide a variety of approaches for me to draw from in my data analysis. I begin with a discussion of Immanuel Wallerstein's world-systems theory. Though not specifically a migration theory, world-systems theory provides a base of economic and global thinking for these frameworks. Then I discuss Pierre Bourdieu's forms of capital, which are excellent for analyzing migration, which is a social pattern (as well as an economic one). The 1980s MIRAB (MIgration, Remittances, Aid, Bureaucracy) theory of Pacific Island economies serves as a specific regional theory of migration, as does the PROFIT (People, Resources, Overseas management, FInances, and Transport) model, which emerged as a response to MIRAB.

Many theories of migration build off of the world systems theory conceptualized by Immanuel Wallerstein. Wallerstein writes that this modern world-economy emerged in the 16th century, resulting from the spread of capitalism (Wallerstein 1979, 6). Viewing the entire globe as a single economic unit like this empowers the social sciences, and its

holistic perspective accounts for understanding larger systems and processes (Wallerstein 1976, 5). The bulk of world-systems theory works to explain the flow of capital among Wallerstein's three economic types of nation-states: the core, which are wealthy and economically specialized nations; the periphery, which have weak economies, poor citizens, and are exploited for their resources by the core; and the semi-periphery, which are both exploited by the core and exploit the periphery, and have an economic and governmental strength in between the two. Samir Amin (1976), another world systems theorist, omits the semi-periphery from his work and highlights the injustices created through dependencies and underdevelopment in periphery nations. Migration theories stemming from world-systems theory are based on an economic logic: since core nations are typified by stable governments, a broader bourgeois population, and higher wages and better economic prospects, it is advantageous for those in the periphery and semi-periphery to migrate to the core. Core countries benefit from this flow of people by receiving both the "best minds" and low-skill, cheap labor out of periphery and semi-periphery countries.

This theory fails to completely capture what happens in the Marshall Islands. Like much of the field of economics, it relies heavily on the economic rationality of humans, when humans do not always act rationally (Ariely 2009; Etzioni 2014). Its worldwide vision also assumes that most people are driven by global systems (as opposed to local or familial systems), but migration to another country or region may not even be considered by someone looking for work, especially when local solutions exist. On top of this, I argue that the RMI does not even fit into the world system as explained by Wallerstein:

its poor citizens and weak economy would categorize it as a periphery state, but not because its labor and resources are being exploited. Instead, the Marshall Islands' economy is primarily shaped by its geography, which makes industry and trade difficult, and it is noticeably short of exportable resources.

The Marshallese migration is furthered, in part, by economic prospects, but they are by no means the only drive for movement. Besides health, education, and other benefits Marshallese COFA migrants seek, the very act of migration furthers the process of migration. As the Marshallese community in Springdale grows, more Marshallese churches are available, more relatives are present, and it becomes easier to leave the Marshall Islands. Douglas Massey names this process cumulative causation, where growing networks and migrant-supporting institutions changes the social context, making migration a more attractive option and an easier process (Massey *et al.* 1993, 451). Cumulative causation is not isolated from economic motives of migration, but it adds an important nuance, creating a more holistic picture of migration patterns beyond the purely economic.

Pierre Bourdieu provides an alternate social theory to the economic-heavy world-systems theory, and his theories are useful in examining the Marshallese diaspora. In fact, Bourdieu's forms of capital were created partly in response to the overwhelming theories centered around economics¹² (Bourdieu 1986, 2). His three forms of capital—economic, cultural, and social—provide a more nuanced and scalable perspective than world-systems theory. Additionally, they give more agency to individuals, providing a view of

¹² Although Bourdieu uses economic language to describe his social theories.

people as more than subjects being moved and shaped by global economic forces. His ideas of cultural and social capital are particularly useful. In its institutionalized state (largely academic credentials and qualifications), cultural capital is one of three most-cited reasons Marshallese migrate to Springdale. All of the Marshallese parents I spoke with in Springdale said that education for their kids influenced their decision to come to the US. Marshallese parents believe completing formal education in the US will earn their children institutionalized cultural capital (e.g., diplomas and college degrees) that can be translated into economic capital by enabling them to get better-paying jobs. Many of the Springdale Marshallese have not completed high school, and most have no tertiary education. This lack of education is one of the reasons¹³ most Springdale Marshallese have low-skill, low-paying jobs. There is a general opinion that US education is superior to schooling in the Marshall Islands, to the point that it is seen as a golden ticket. Education leads to economic security, and the cultural capital is recognized: Marshallese who complete graduate and professional degrees are highly esteemed by the Marshallese community.

Bourdieu's concept of social capital is also crucial for parsing the Marshallese diaspora. While cultural capital is largely an individual attribute, social capital cannot exist without networks of people. Social capital consists of the resources or potential resources that are available to one through the people they know (Bourdieu 1986, 9). The Marshallese social networks in Springdale are robust for many reasons: there are relatively few Marshallese in the world, so belonging to that group is inherently

¹³ Other reasons include language barriers, lack of formal work experience, and (based on the recent Cargill labor discrimination settlement) race.

exclusive; they speak a unique language; since most Marshallese come from one of two population centers in a small country, most are related through marriage or blood; Marshallese social structure is communal, and resources, knowledge, celebrations, and housing are all shared; religion is important, providing another layer of internal networks; and their cultural, national, and linguistic differences from the other minority and majority groups in Arkansas unite them with each other. This wealth of social capital means that new migrants do not have to worry about housing or food, enabling them to focus on the steps needed to find employment: applying for a social security card, a driver's license, and work. They merely have to use their credit within the collectively-owned social capital within their networks (Bourdieu 1986, 9). Importantly, this social capital means that new Marshallese migrants in Springdale have a community to speak with, celebrate with, worship with, visit, and find support in. This extensive network doesn't just allow migration from the Marshall Islands to Springdale, but it makes in-country migration easier, too. It is common for Marshallese migrants to live in multiple cities and states after they enter the US. Lastly, family in the States purchase one-way tickets for relatives in the RMI come to the US. Since Marshallese in the US tend to have higher incomes, they are able to purchase expensive plane tickets, especially when they receive their income tax rebates. I rely heavily on Bourdieu's concepts of social and cultural capital in my data analysis below.

Where Bourdieu's idea of social capital converges with Pacific-specific migration theories is in remittances. The extensive networks of friends and family between the US and the RMI results in remittances being sent back to family in the Marshalls.

Remittances are key to the MIRAB (MIgration, Remittances, Aid, and Bureaucracy) and PROFIT (People, Resources, Overseas management, Finance, and Transport) models of Pacific migration. The MIRAB model was proposed in 1985 as a social-economic model for Pacific Island states and went unchallenged until the last decade. The authors write that citizens from Pacific nations leave their islands, where poor job prospects and few resources dampen the economy, for jobs on mainland states (Bertram and Watters 1985). Although it addresses labor migration and remittances, the PROFIT model, proposed as a counter to MIRAB, relies on certain economic attributes (offshore banking centers and export manufacturing) that are insignificant in the RMI, making the model little applicable to the country. The migrant laborers under the MIRAB model send remittances back home, where the extra income becomes steady and expected. Importantly, these labor migration flows happen between previous colonizer/colony countries, as lingering ties and reparations make this easier. In addition to remittances, Pacific states come to depend on foreign aid (again, typically taking place between previous colonizers and colonies) as consistent income to fund infrastructure development and operating expenses (Bertram and Watters 1985). In this sense, the MIRAB model is useful in examining the RMI and the US, as these key attributes—remittances through migrant labor and heavy foreign aid—accurately depict the relationship between the US and the RMI. The Marshallese government relies on income from the US to operate. As with education, all of the Springdale Marshallese I interviewed listed employment as one of the reasons they moved to the US.

Bertram and Watters write that families decide, as a unit, to send their members out of the country to work, creating a steady migration. The family unit is significant in the MIRAB model, as it provides a slightly more complex view of Pacific Island societies as structured through relation rather than as a mass of individuals, but MIRAB is still a cold, pragmatic economic model (à la world systems theory) that gives little credit to the agency of individuals and to noneconomic reasons for migration. Here, Bourdieu's social and cultural capital fill in many of the gaps, but so does a recent critique of MIRAB. In 2006, Marsters *et al.* criticized this very idea, arguing that remittances “represent flows of goods, money, aroha and identity-forming values, which play an integral part in constituting individual and social experience in ways more significant than the simply economic” (Marsters *et al.* 2006, 32). Their view of MIRAB provides a constructive contemporary perspective. They agree with Bertram and Watters' idea of “transnational corporation of kin,” or “family or kin units in the small Pacific societies [which] act and calculate on a transnational scale, especially via the regional labour markets” (Bertram and Watters as quoted in Marsters *et al.* 2006, 39), but do not agree that these units act harmoniously or rationally. Pacific Island families are not traditionally nuclear, wherein the standard family unit is just a set of parents and their children, and this means there is not always a clear head or decision-maker in each unit. Additionally, individuals within these units have their own interests and agency, which may conflict with unit needs or objectives. I found a similar pattern while interviewing Springdale Marshallese. One father I interviewed noted how one of his sons married “an American” [white] woman and acted differently from the traditional Marshallese way: he moved away from the rest

of his family, seldom visits, and is not receptive to housing family at any time. To this father, this deviated from the family-centered obligation that Marshallese relatives have toward each other. Marsters *et al.* also point out some other Pacific migration trends that fit the Springdale Marshallese: migration and remittances are fluid, with migrants moving to multiple locations, and the idea of home does not always remain the country they left (Marsters *et al.* 2006, 41). This is because identity is not static; it is always reformed in some way while abroad.

Structural Violence and Global Health Disparities

All of the Marshallese I spoke with in Springdale listed health as one of the reasons they moved from the Marshall Islands to the United States. The Marshall Islands is in a poor state of health, and Marshallese in Springdale and other US cities carry many of these problems with them as they move. The increasing realization that many of the world's problems must be solved through global efforts—not the actions of a few nations, but a collaborative acknowledgement and commitment by most nations—has made *global health* a trendy and emerging term. Governments, philanthropists, academics, and health professionals all use the term. Despite that, it is seldom defined, and its meaning continues to be debated. The search for a global health definition began in the 1990s, when Yach and Bettcher wrote about the globalization of public health in a two-piece article in 1998. They used Anthony Giddens' ideas of globalization to connect the transnational processes of economics, politics, and social interdependence with public health, pointing out that a new field was emerging (Yach and Bettcher 1998, 735). In 2001, Bunyanavich and Walkup added that most uses of the term global health had a

common factor: an emphasis on health equity for all of humanity (Bunyanavich and Walkup 2001). This notion of health equity for all has become one of the few attributes that all proposed definition of global health have in common. Ilona Kickbusch was one of the first to propose a solid definition for global health: “Global health refers to those health issues that transcend national boundaries and government and call for actions on the global forces that determine the health of all people. It requires new forms of governance at national and international levels which seek to include a wide range of actors” (Kickbusch 2006, 561). One of her most important contributions to defining the term was a call for multidisciplinary approaches and an emphasis on global efforts to treat global problems. Kickbusch’s and Koplan *et al.*’s definitions are the most widely used today. In 2009, Koplan *et al.* systematically define global health against international health and public health, ending by defining the field as “an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level care” (Koplan *et al.* 2009, 1995).

Global health, although a relatively new field, is relevant because its very nature is to understand the myriad processes and social determinants that affect health, working at a global scale and local contextual perspective simultaneously. The health of the Marshallese diaspora can only be understood through its colonial history, continuing postcolonial ties with the US, geography, economics, and social context. All of these

factors must be considered individually and in concert with each other in order to construct an accurate picture of the state of Marshallese health and its influencing factors.

In addition to the subject of global health, the idea of structural violence is essential to understanding the context for the Marshallese diaspora, as well as the health of the Marshallese within it. Johan Galtung's 1969 concept of *structural violence* provides the language that at last empowered activists, academics, and others to identify and discuss concepts that could not be articulated otherwise—such as the structural violence of colonialism, which I discuss in the following chapter. How exactly can you grasp the idea of social inequality, or of the oppression of the colonized by the colonizer, if they are not single acts of violence or individual actors? Structural violence fills the linguistic and conceptual void opened by such questions, allowing for select nuances of many power structures to be approached, named, and handled. Structural violence is violence that cannot be linked to single actors, or to specific people who commit violence (Galtung 1969, 170). This concept is applied to systems of power and unequal relationships between nations or communities rather than individuals. It is manifested by our institutions, our laws, and even our customs. Psychiatrist James Gilligan built on this idea of structural violence by pointing out that it is always preceded by inequality. Differences in privilege and power create structural violence (Gilligan 1997, 192).

Medical anthropologist Paul Farmer continued Galtung's conversation by applying the idea of structural violence to his experiences caring for patients in Haiti. He wrote that "sickness is a result of structural violence: neither culture nor pure individual will is at fault; rather, historically given (and economically driven) processes and forces

conspire to constrain individual agency. Structural violence is visited up all those whose social status denies them access to the fruits of scientific and social progress” (Farmer 1999, 79). Like Galtung, Farmer recognizes that structural violence cannot be reduced to individual actors or cultural issues. This, admittedly, makes the concept difficult to grasp. After all, who can name all of the complex structures and systems that sustain structural violence? Even so, its multidisciplinary and holistic lens is a useful frame for more accurately understanding and addressing inequalities. Farmer also asserts, clearly, that structural violence is a global health problem. He writes that “societies built on deep inequality consist of wall-to-wall structural violence,” and that “violence and diseases are so tightly bound to poverty and social inequalities” (Farmer 2006, 143). Farmer often incorporates the work of economist and Nobel laureate Amartya Sen into his articles. Sen also links social inequality and oppression—structural violence—to global health: “Good health does not depend only on health care. It also depends on ... the extent of inequality and unfreedom in a society” (Sen 2008, 2010).¹⁴ Both Farmer and Sen posit structural violence around inequity—conveniently, a base for all contemporary definitions of global health.

Seth Holmes is a contemporary medical anthropologist who studies structural violence and its effects on the health of certain communities. I find him particularly helpful because he has spent time studying structural violence around Mexican migrants in the US. While he provides useful insights into specific and intentional forms of

¹⁴ The omissions from this quote, which is an introductory letter, are other items in a list of factors that determine health. The full quote is as follows: “But good health does not depend only on health care. It also depends on nutrition, lifestyle, education, women’s empowerment, and the extent of inequality and unfreedom in a society.”

structural violence maintained by the US on Mexican migrants, most relevant to my study of Marshallese COFA Migrants are his understandings of perceptions of structural violence in a marginalized group. For instance, the Marshallese COFA migrants attributed many of the health and employment problems they face to issues within their community. While not at all universal, they attribute diseases like diabetes to their personal diets, or unemployment due to their cultural approach to time. Holmes writes about Mexican migrants entering the US illegally, “Yet, metaphors of individual choice deflect responsibility from global economic policy and US border policy, subtly blaming migrants for the danger—and sometimes death—they experience” (Holmes 2013a, 153). Holmes is saying that the hardships Mexican migrants face while crossing the border are often blamed on the migrants themselves, rather than on the policies that are designed to lead them to the choices they make.

In another article, this one also on Mexican migrants in the US, Holmes points out a similar concept. This time, he speaks specifically about medical professionals. What he points out—that health problems are often seen as issues of poor choice rather than the result of wider structural forces—is an opinion I witnessed while speaking with nurses in Springdale. Holmes writes, “Thus, the victim of social inequalities is blamed for her poor health and the social inequalities themselves are left unexamined and unchallenged” (Holmes 2013b, 880). I saw this opinion and its opposite in two different nurses who work with the Springdale Marshallese: one noted that the community’s health problems were a result of personal decisions and culture, while the other was adamant that US policy in Springdale and inequalities back in the RMI were the root of the health

problems. It is this second opinion that I find most valid based on the data I collected over the course of writing this paper.

I rely heavily on the idea of structural violence in my data analysis. By framing my data in such a way, I not only have a name for the systems of power I see, but I can conveniently incorporate the Marshall Islands' postcolonial relationship with the US, Bourdieu's forms of capital, economics, geography, and global health. Under the concept of structural violence, all of these are relevant, and all are necessary in understanding the history that leads up to the health of the Marshallese diaspora.

A good example of how these tie together is the US occupation of Kwajalein and its domino effects on Marshallese health today. During World War II, the US military seized the military base on Kwajalein Island from the Japanese navy. They have occupied the land—the largest piece of land in all of the RMI—since then, holding on to it for its strategic placement between Asia and North America and for the lack of land and property surrounding it, which provides good conditions for testing its expensive and failed Ground-based Midcourse Defense System.¹⁵ The notion of racial superiority disseminated through Orientalism and coloniality of power justified the displacement of Marshallese from the islands in Kwajalein's missile path at the height of testing during the Cold War. Those who formerly lived on these tiny islands joined the nuclear refugees from Bikini and Rongelap on tiny Ebeye island only four miles from Kwajalein. This population increase made subsistence agriculture and fishing impossible on such a small

¹⁵ The United States' Ground-based Midcourse Defense System (GMD) is a strategic system to intercept warheads on course for the United States. In theory, it tracks missiles (anticipated to have nuclear warheads) via satellites and launches ground-based missiles to physically destroy them while in the upper atmosphere. Decades of testing have produced few successful mock intercepts, despite the program's hefty \$40 billion price tag (Willman 2014, n. pag.).

piece of land, and food aid had to be shipped in to keep the residents from starving.

Ebeye's population exploded as Marshallese moved there from other islands in order to secure high paying day jobs for the military on Kwajalein or to live with relatives who had those jobs. Meanwhile, the diet of heavily processed imported food, a drastic switch

from a historical diet of indigenous produce and fish, led to the current high rates of

noncommunicable diseases. Now, Ebeye has one of the highest prevalences for type 2

diabetes in the world, and it is also one of the most overcrowded island slums in

existence. The structural violence—the harm caused by gross inequality—stewed up from

a history as the subaltern in the US-RMI postcolonial relationship is clear: US citizens

live comfortably and with plenty of space and resources on Marshallese property while

Marshallese citizens are overcrowded, poor, and unhealthy only four miles away. These

conditions lead to migration to the US for employment, health services, and education,

and this is how many end up in Springdale—and why so many there are in ill health.

Chapter 3

Data Analysis

Introduction

Based on the data I collected through interviews and research into published texts, I argue that the contentious and continuing colonial relationship between the United States of America and the Republic of the Marshall Islands—while in some ways paternalistic and beneficial to the RMI—is boon and bane for Marshallese COFA migrants. It maintains a structural violence that causes health and economic problems in the Marshall Islands, making it easy to move to, live in, and work in the US, while also creating special hardships for the Marshallese once in the US.

In this chapter, I will begin by describing the Compact of Free Association (COFA), listing its history, benefits for the Marshall Islands and the United States, and the unique migrant status that it provides Marshallese migrants in the US. I discovered that the COFA is key to understanding the health of the Marshallese diaspora in Springdale, as it influences the history of their homeland, the health conditions in the RMI, the continuing colonial relationship between the US and the RMI, and the politico-structural barriers to health that the Marshallese face in Springdale. I then address the biggest barrier to Marshallese health in the US—lack of access to Medicare under COFA migrants status—which brings together the subjects of postcolonialism, immigration, and global health. I will address health as a major factor for migration; the prospects for better healthcare in the US, as well as poor population health in the RMI, are significant in Marshallese movement. I end with a discussion on the patterns and barriers of health

around the Marshallese population in Springdale, working with a wide range of perspectives: Marshallese COFA migrants, medical personnel, and government representatives. These patterns and barriers, once identified, are potentially useful in addressing or improving the health of the Marshallese population in Springdale.¹⁶

Marshallese and the Compact of Free Association

The key to understanding all of these issues—the United States’ long colonial history with the Republic of the Marshall Islands, the steady and increasing migration to the States, and the structural issues affecting Marshallese health both in the RMI and in the US—together is the Compact of Free Association (COFA). Three nations hold Compacts of Free Association with the United States: the Republic of the Marshall Islands, the Republic of Palau, and the Federated States of Micronesia.¹⁷ These three COFA nations all occupy the Micronesian region—the swath of islands and ocean in the North Pacific Ocean between Hawaii and the Republic of the Philippines. After World War II, these nations were made UN Trust Territories of the Pacific Islands, administered by the United States (Friberg, Schaefer, and Holen 2006, 124). Each of them eventually petitioned for independence, at which time they each made a COFA with the US.¹⁸ While ready for independent rule, the countries were not deemed economically stable or self-sufficient, which is largely why these agreements were made. The US was also worried

¹⁶ Much of the data I found is not present in any literature, largely because there is little literature on the topic. Much of my data also complements the three bodies of literature I ground my thesis on: postcolonialism, immigration, and global health.

¹⁷ The terms of the three Compacts do have small differences, but they are largely similar to each other.

¹⁸ The RMI and the FSM became sovereign nations in 1986. Palau became independent in 1994.

that these Pacific Islands could be used as a theater against them, as they were in World War II (U.S. Government Accounting Office 2003, 5). These Compacts are invaluable to the COFA nations, for the reasons I list below.

The RMI is granted many privileges through the COFA, which has already been renewed once, in 2003.¹⁹ The nation is given considerable financial aid every year by the US, which it uses to run its government, provide for its citizens, build infrastructure, and other actions. On top of this, the Marshall Islands is allowed to use US bills as its official currency. This has the valuable economic benefit of keeping its local economy stable, as it is tied to the relatively stable and powerful US dollar. One of the other major benefits is that Marshallese citizens have unrestricted, visa-free travel and work privileges in the US. Such entitlements are invaluable, and many who do or would like to emigrate to the US from other areas of the world would no doubt wish to have something similar.

Because of this Compact status, those who move to the US from the Marshall Islands are legally not immigrants. In the broad understanding and common usage of the word—“a person who comes to a country to live there” (*Merriam-Webster’s Collegiate Dictionary* 2009, 621)—they are immigrants, but under US law, Marshallese citizens living in the US reside in a different legal category. The reason for this alternate migrant status is because the Compact exempts them from certain rules and processes (e.g., obtaining visas, limits on time in country) that apply to other immigrants.

¹⁹ The original Compact distributed funds for 15 years, and was extended an additional 2 years during negotiations. The renewed Compact terms operate for 20 years. The FSM also renewed its Compact with the US in 2003.

The *Arkansas Democrat-Gazette* lists, vaguely, that they have a “nebulous legal status” (Bowden 2013, n. pag.). Because Marshallese migrants are exempt from the processes facing other immigrants but are also exempt from many of the privileges of US citizenship, this “nebulous” identity is right on the mark. Newspapers and governments both struggle to even name Marshallese migrants. Arkansas Advocates for Children and Families labels Arkansas Marshallese as “non-immigrant, but ‘lawfully present’” (Kellams 2013, 1). An extensive University of Arkansas study said that migrants from the Marshall Islands “apply for entry as ‘nonimmigrants without visas’” (Jimeno S. 2013, 9). The Asian & Pacific Islander American Health Forum refers to Marshallese migrants in the US as “legally residing non-citizen nationals,” in addition to “COFA Migrants” (Asian and Pacific Islander American Health Forum 2014b, n. pag.), and Hawaii’s Department of Human Services similarly refers to them as “lawfully present noncitizens,” as well as “COFA residents” (Abercrombie and McManaman 2014, 1). This lack of a common term for Marshallese in the US shows not just the nebulous legal status of these migrants, but how difficult it is to discern their place among the United States’ complex health laws. I refer to Marshallese who move to the US and do not have US citizenship as “Marshallese COFA migrants,” which accurately describes their politico-legal status in the US and sets them apart from COFA migrants from the FSM or Palau. The term “COFA Migrants” is currently used by academics who study or work with the COFA nations.

It may seem as if the US is a benevolent patron to the COFA nations, giving freely in return for very little. The US does get something out of the deal, however. Through the

Compacts, the US is granted full military and defense responsibility for the COFA nations.²⁰ This means it is obliged to defend the countries from attack, which appears to be a considerable potential expense for the US without any sacrifice on the part of the COFA nations. However, this grants the US exclusive military rights on land and in the ocean surrounding these countries. Since these Pacific nations span thousands of miles above the equator between North America and Asia, this gives the United States de facto military domination of the North Pacific Ocean—an invaluable strategic acquisition for a country with many global economic prospects (and potential enemies of state). The US military also enlists a high percentage of the population of COFA nations into its armed forces (Shek and Yamada 2011, 4). Some have claimed that COFA migrants suffer far higher casualty rates per capita compared to other demographics in the US military (Azios 2010, n. pag.).

In the Marshall Islands, specifically, the US leases much of Kwajalein Atoll, which houses its Ronald Reagan Ballistic Missile Defense Test Site (or Reagan Test Site). The Reagan Test Site is considered an invaluable strategic military acquisition, both for its geographical location in the Pacific and for its use to test its Ground-Based Midcourse Defense (GMD), which is a strategic system to intercept incoming warheads. As Calvin explained to me, “The Marshall Islands through Kwajalein is like a shelter to the United States. A helmet to protect.”²¹

²⁰ Palau has refused, however, to have nuclear weapons on its territory unless required during war.

²¹ Calvin, interview with author. September 8, 2014. Transcript.

Calvin is slender, Marshallese, with gray hair and a perpetual smile. He speaks in a grainy, but not unpleasant voice, which, if not speaking, is laughing. He was born in 1948 in the Marshall Islands, during the first years of US occupation there, where he was named after a US military officer stationed there. He prides himself on looking younger than other Marshallese his age (66), a result of his Adventist religious lifestyle, which emphasizes exercise, vegetarianism (although Calvin and his family are not vegetarian), and avoidance of substances like alcohol, tobacco, and caffeine. He is retired, but fills a number of volunteer community roles, from starting and tending greenhouses at a school to acting as Springdale prison chaplain for Marshallese. Calvin found me, somehow getting ahold of my phone number and calling me while I was in California, arranging my research. Despite never having met me, he became my primary contact and friend, including me in family meals and celebrations and introducing me to many Marshallese in Springdale. His connections through community work and respected position as pastor granted me access to interviews that I may not have gotten otherwise.

The tests done by the Reagan Test Site on Kwajalein have received much criticism for being exorbitantly expensive (costing over \$40 billion at the time of writing) and largely unsuccessful (Willman 2014, n. pag.). The Marshallese suffer heavily from the US occupation of Kwajalein, of which I explain the structural violence at the end of my literature review.

All Marshallese I spoke with know of the Compact. Carmen, Aaron, and Calvin all acknowledged they were lucky to have the travel and work privileges that they do, but each of them is also frustrated with the limitations the COFA places on Marshallese

COFA migrants attempting to get health care. Aaron told me, “It does not make sense in the Compact that we live, work, go to school, but not get medical attention! We need that.”²²

Aaron is the youngest Marshallese adult I interviewed. He was born in the Marshall Islands but moved to Springdale when he was 10 years old. Despite that, he misses the RMI, which he calls home. He is a Marshallese community organizer at the Northwest Arkansas Workers’ Justice Center, and he acts as Executive Director of the new nonprofit Marshallese Education Initiative. He is one of the best-known Marshallese men in the area, due to his close work with Marshallese employees, educating them on their rights as workers and advocating for the Marshallese population as a whole. He has a reputation as being talkative, which he is, and is easily identifiable by his front two teeth—rimmed in gold and inscribed with a gold “A” and “L”, one on each tooth, in a lavish font. He jokingly refers to Springdale as “Chickendale,” due to its reputation for poultry processing plants and companies, and he is a passionate and invaluable resource to the Marshallese community living there. Aaron is in the arduous process of becoming a US citizen.

Manuel saw the Compact as, partly, a way for the US to purchase forgiveness from the Marshallese for the spate of nuclear weapons tests it performed in the Marshalls. “They say it’s a free agreement between the US and the Marshall Islands, because of what the US did: drop the atomic bomb. They give us some lumps of money, and also

²² Aaron, interview with author. September 9, 2014. Transcript.

agreement for us to come and go without visa.”²³ He thinks the compensation wasn’t good enough for the destruction (societal and physical) caused by the weapons tests.

When I interviewed him, Manuel was a chaplain for the Tyson Foods plants in Springdale. He and his family have since moved back to Wisconsin. He spent his days searching for employees who miss work, providing spiritual advice, running religious ceremonies outside of work (e.g., weddings), and mediating conflicts between factory floor workers and management. He speaks with sad, deep set eyes and a soft voice, and he takes pride in his children, the oldest of whom is pursuing a degree in engineering at University of Arkansas.

As we will explore below, health is one of the primary reasons Marshallese choose to leave the Islands for the States. The Marshallese get, in a sense, a bait-and-switch from the US: they are provided the possibility of great healthcare and the means to get to the US, but face limited health options due to the very means (COFA) that allow them to come to the US. As I’ve alluded to above, the unique COFA status merely fell through the cracks of the United States’ health laws. The COFA and COFA migrant status shape the way Marshallese move to and within the US. An international legal agreement, it affects them both in the US and the RMI, a structure that has both positive and negative effects on their migration patterns, work eligibility, and population health.

Marshallese COFA Migrants and Health Insurance Eligibility in the United States

More than anything else, the Marshallese in Springdale told me they want better health insurance access and coverage. Once in Springdale, this is their biggest issue.

²³ Manuel, interview with author. September 8, 2014. Transcript.

Calvin told me, “The challenges we are facing here for [those of] us who are not citizens? Medical assistance. Some of us have no insurance.”²⁴ Carmen ended up in the US for health reasons—she wanted to avoid another miscarriage, which she attributes to poor healthcare in the RMI. She is frustrated with the lack of health insurance options for Marshallese in Springdale: “But how do you have that [good medical attention] when you don’t have insurance, and you don’t have access to maintenance health?” She said that not having health insurance keeps Marshallese from making frequent health visits, and this keeps the community from being practiced enough to navigate healthcare. “Or you don’t have the knowledge? You don’t know about anything. And when you don’t know about anything, you cannot really critically navigate your way around the conversation so you know what to ask.”²⁵

Carmen Samuel Chong-Gum is the Consul General of the RMI Consulate in Springdale. She helped get it started in 2009, and has held the position since then. She is wide-eyed and carries herself with an air of business, though she is not at all unfriendly. As I mentioned above, she first came to the US (Hawaii) to get better prenatal care after she miscarried in the Marshall Islands. She ended up in Springdale after moving there from Missouri as her husband and brother pursued work. As an official, she is known by all in the Marshallese community in Springdale, and she is passionate about Marshallese rights. She is particularly touched by the high rate of type 2 diabetes among the Springdale Marshallese, which affects her as well.

²⁴ Calvin, interview with author. September 8, 2014. Transcript.

²⁵ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

Most Marshallese with health insurance receive their coverage from their employers. This happens mostly in the poultry industry, since the majority of Marshallese work there.²⁶ Calvin told me his wife started working for Tyson primarily to get health insurance coverage for the family. The Marshallese community knows that Tyson and other poultry plants provide health insurance to their employees. Because of this, the ease of being hired (no high school diploma or proficiency in English needed), and the above minimum wage salary, working for Tyson is a triply attractive prospect. Although he doesn't work for any of Springdale's poultry plants, Aaron's job at Northwest Arkansas Workers' Justice Center means he works closely with those who do. He told me, "One of the good things about working for poultry plants is that they have good benefits. I could not say excellent, but I could say good. Meaning that they get health insurance, and also kids get health insurance. That's one of the major positive things about poultry."²⁷ I called Tyson to confirm the benefits their employees receive. Debbie Hatfield, Director of Benefits, Training, and Auditing at Tyson, listed the company's coverage for me. "All full-time employees (30 hours/week or more), after 59 days of employment, receive health insurance. This includes dental and vision. Additionally, there are more buyout options. Also, full-time employees get basic life and dismemberment insurance at no charge."²⁸ Debbie told me that this coverage does extend to immediate family—spouse and children—as well.

²⁶ The best figure on this comes from the University of Arkansas study on immigrants in 2013, in which 63 percent of Marshallese surveyed reported having health insurance. Of these, 83 percent said their insurance was provided by their employer (Jimeno S. 2013, 5).

²⁷ Aaron, interview with author. September 9, 2014. Transcript.

²⁸ Debbie Hatfield, phone interview with author. September 5, 2014.

This family coverage isn't convenient for Marshallese households, however. This is because Marshallese households typically include far more family than the nuclear family many US institutions recognize as default: two parents and their children. Aaron, who mentioned above that insurance through Tyson and other poultry plants is good for the Marshallese, takes issue with this. "But family mean their kids and their wife. Not grandparents ... and one of the things also worse is that there's a lot of Marshallese kids who are living with relatives—cousins, family members. Their parents send them to them. And they're not having insurance also."²⁹ Many Marshallese families I spoke with were housing such non-nuclear family members. Calvin, for example, housed his grandson, whose parents live in Hawaii. Since his grandson is not immediate family, he is not covered by the Tyson insurance that Calvin's wife receives for the family. He was born in the US, however, so his US citizenship and low-income family status gives him health insurance coverage through Medicaid's Children's Health Insurance Program (CHIP).

But even Marshallese who have health insurance still find it difficult to afford healthcare. Manuel receives health insurance through his chaplaincy position at Tyson. This covers his family, too. He says it's not as good as his coverage from jobs at hospitals in other states, because it's expensive. "We pay a lot of money. You have, like, a \$30 co-pay." This is difficult for low-income families to pay. Manuel said it was also difficult because of the Marshallese budgeting problem he perceives in the Springdale Marshallese community, and which I discuss as a barrier to health below. "That's the

²⁹ Aaron, interview with author. September 9, 2014. Transcript.

problem with some of our employees, too. They get their paycheck and run it out in a couple days, and then it's gone. And when they have some kinds of sickness, they don't have any money to see the doctor, because they don't have \$30.”³⁰ Even Springdale Marshallese who have health insurance don't have the additional money necessary for items like co-pays and deductibles to use the insurance. A small health survey done in 2005 by the University of Arkansas lists finances as a major socioeconomic barrier to Marshallese in northwest Arkansas, even for those with insurance. Outstanding hospital bills, or even the anticipation of expensive health care costs, deter Marshallese from seeking treatment at hospitals (Williams and Hampton 2005, 324).

The younger generations of Marshallese—those born in the States—typically have health insurance in Springdale. Their US citizenship makes them eligible. “Yeah, and one thing I forgot to mention to you,” Calvin said, “is all the kids who are born here—they are entitled for food stamp. So they go to see the doctor and dentist and they get healthcare.”³¹ Since they are US citizens, Marshallese children born in the US are eligible for low-income government support, such as food aid and health insurance. Health providers in Arkansas witnessed the same thing. From her years of hospital work in northwest Arkansas, as well as a report she wrote while working on her Master of Science in Nursing, Dawn also pointed this out: “As far as children, it's [insurance] not as big of an issue, because generally they're meeting the low-income category and they're on Arkansas Medicaid.”³²

³⁰ Manuel, interview with author. September 8, 2014. Transcript.

³¹ Calvin, interview with author. September 8, 2014. Transcript.

³² Dawn, interview with author. September 12, 2014. Transcript.

Dawn, a nurse, is the Assistant Director of the Emergency Department at Washington Regional Medical Center in Fayetteville, which borders the south end of Springdale. Before that, she headed the emergency department at Northwest Regional Medical Center in Springdale. A *ribelli*, or “white person,” she had a different perspective on the Marshallese community in northwest Arkansas, noting Marshallese trends and patterns in the emergency room. She wears a naturally stern face and speaks with a southern accent. Dawn doesn’t just see the personal health problems the Springdale Marshallese face. In her job, she sees the economic one it puts on hospitals and Marshallese patients as well.

The most vulnerable demographic of Marshallese are the older ones—those past working age. This group suffers the most health problems, cannot work to receive employer health insurance, and are not US citizens, making them ineligible for Arkansas Medicare. Dawn noticed that few older Marshallese make hospital visits. “We generally don’t see as many older Marshallese, and maybe that’s just because they haven’t lived here long enough.”³³ There could be a number of other reasons for this. Since older Marshallese have the most difficult time getting health insurance, they may not visit as often simply because they can’t afford to. There may be far fewer older Marshallese, perhaps because they are less likely to leave the Marshall Islands for the States when older, or because of a high mortality rate—few Marshallese live past their 70’s in the Marshall Islands (Ichiho *et al.* 2013, 78).

³³ Dawn, interview with author. September 12, 2014. Transcript.

Another explanation could be the trend of domestic migration for health, as many Marshallese told me: older Marshallese leave Springdale for Washington and California, where they are eligible to receive Medicare coverage. Aaron was one of the many I interviewed who brought this up. “And I could say that a lot of our elders are moving out from Springdale because health concerns. They don’t have Medicaid here, so that is why they’re moving to the West Coast, like California, Washington state. So they can get those benefits.”³⁴ As I discuss in the previous chapter, there is a common pattern of domestic migration from Springdale, Arkansas to Washington and California. Again driven indirectly by their COFA migrant status (this ever-present structure), older Marshallese who are unable to work from old age or ill health and do not have health insurance often move to California and Washington, where they will be eligible for Medicaid and Medicare and can receive health insurance.

The ineligibility of Marshallese COFA migrants to receive Medicaid and Medicare in Arkansas frustrates the Springdale Marshallese. Aaron told me that in his opinion, “Arkansas has one of the worst health systems in the US.”³⁵ This is because of the difficulties Marshallese face in getting healthcare: price and citizenship eligibility. Lack of US citizenship removes the eligibility for Medicaid, and price makes it difficult to afford private insurance or to pay the necessary co-pays and deductibles on employer-provided insurance. I cover the cost of healthcare below, and I will explain here how Marshallese COFA migrants fit into Arkansas health insurance, legally. Calvin and

³⁴ Aaron, interview with author. September 9, 2014. Transcript.

³⁵ Aaron, interview with author. September 9, 2014. Transcript.

Carmen were the first to bring this up. They said that many Marshallese were excited when the Affordable Care Act was rolled out. It appeared to offer what Marshallese in Arkansas longed for: health insurance for all, regardless of pre-existing health conditions or income. Both of these hit the Springdale Marshallese population particularly hard, as they have many pre-existing conditions (largely from when they lived in the RMI) and little money. But many Marshallese who signed up were disappointed as they didn't get the coverage they were hoping for—or any coverage at all. Visibly frustrated, Carmen told me, “For the ones that are not US citizens by birth, many—I don't know how many—have applied for Obamacare and they have received their cards. But people are hearing rumors that they have to pay even though they have that card ... We were told it was free. People were rushing to apply, but now there is a different story about that.”³⁶ The Affordable Care Act (ACA) is difficult to understand, especially in relation to such a niche politico-legal group such as Marshallese COFA migrants. Only two of those I interviewed could explain how Marshallese fit into the Affordable Care Act.

Sadie, a public health nurse who has worked with the Marshallese community in northwest Arkansas for about 15 years, prefaced her explanation with a warning: “I am really not in a position to be quoted on this, and not in a position to speak for the health department or for the government.” Despite her reservation, her assessment on the mark. “We know that some Marshallese that signed up for Affordable Care didn't qualify for actual insurance because they were under income, that they were turfed over to Medicaid, and that they're now being rejected out of that Medicaid.” The Affordable Care Act

³⁶ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

(ACA) offers potentially subsidized health insurance to all residents of the US, depending on income. This income is based against Federal Poverty Lines (FPL), which varies depending on your total household income and total household size.³⁷ The ACA also provided the option for states to expand who is eligible for Medicaid in the state. “Medicaid is a state-administered federal program,” Sadie told me. “Every state can waiver that Medicaid Act and include special interest groups. We have not been able to do that in Arkansas.”³⁸ In Arkansas, all COFA migrants (In addition to Marshallese, Palauans and those from the Federated States of Micronesia: Pohnpeians, Chuukese, Yapese, and Kosraen) are ineligible for Medicaid.

Sadie is a nurse, and she has worked with the Marshallese community in Springdale for years. She is the nurse coordinator for the Marshallese-Latino Outreach Team, a division of the Arkansas Department of Health, and she helped start the Dr. Joseph H. Bates Outreach Clinic, which, although small, provides affordable care to the Marshallese community in northwest Arkansas. She is *ribelli*, though she knows the Marshallese very well. She acted motherly toward me, and she provided an important public health perspective on the macrostructural forces affecting health in the Springdale Marshallese community.

³⁷ Though in reality it is a bit more complicated, the ACA’s rule of thumb is that households making under 400% FPL are eligible for reduced premiums on health insurance, those making under 250% FPL are also eligible for reduced deductibles, copayments, and lower maximum out of pocket costs, and families or households making less than 138% FPL (in states with expanded Medicaid) or 100-133% (in states without expanded Medicaid) qualify for Medicaid health coverage (ObamaCare Facts 2014, n. pag.).

³⁸ Sadie, interview with author. September 11, 2014. Transcript.

Pearl McElfish, Director of Research at University of Arkansas for Medical Sciences and project lead on the upcoming \$2.1 million grant to study diabetes in Marshallese families in northwest Arkansas, has studied this specific issue in depth. She also told me that Marshallese COFA migrants were eligible for the subsidized health insurance plans under the ACA, but that their income levels were usually too low for them to fit into that bracket. Instead, their income puts them into the lowest bracket—Medicaid expansion—which, unfortunately, they are ineligible for. At a practical level, Marshallese without US citizenship are denied federal health insurance assistance in Arkansas.³⁹ Major solutions to this predicament are all difficult: make US citizenship easier for Marshallese COFA migrants to attain,⁴⁰ address structural issues that keep the Springdale Marshallese a low income community, or pass state legislature making COFA migrants eligible for Medicaid expansion.

Pearl, like Sadie, is one of the *ribelli* who are very familiar with the Marshallese community. From her position as research director, however, her knowledge is more data-based and less relationship-centered. A busy woman, she talks fast and would answer my questions while simultaneously emailing me papers and resources. With the University of Arkansas as a resource, she is a powerful advocate for Marshallese and other marginalized communities in Springdale and northwest Arkansas.

³⁹ Of course, as mentioned above, states like Washington and California have passed legislation making COFA migrants eligible for Medicaid and Medicare.

⁴⁰ Several of the Marshallese I interviewed in Springdale expressed their desire for a US citizenship. Only one ethnic Marshallese I interviewed had a US citizenship which enabled him to work as a Springdale police officer, a job that requires US citizenship. Only one Marshallese citizen—Aaron—was in the process of applying for citizenship. He described this process as arduous and lengthy.

Pearl also informed me about the history that led up to this tricky situation. After the creation of the Compact of Free Association between the RMI and the US in 1986, Marshallese COFA migrants were included in many federally-funded social support programs, such as Medicaid (Asian and Pacific Islander American Health Forum 2014a, n. pag.; US Government Printing Office 1996). In 1996, US President Bill Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) into law. This bill was commonly called “Welfare Reform,” and it aimed to do just that—fix the welfare system, which was spending more money to cover more people for longer periods of time. Many perceived these programs to be wasting taxpayer money, or that people with poor work ethic were taking advantage of these systems. The bill drastically reduced the amount of money spent on government social services, as well as the amount of people receiving these benefits. A number of specific immigrant groups were excluded from Medicaid, including COFA migrants (US Government Printing Office 1996). Some of these groups regained coverage, but COFA migrants failed to. After only a decade, COFA status for Marshallese had lost a key element, and its small size, complexity, and lack of representation in US domestic politics have caused it to fall through the cracks in the US legal system.

Before the COFA had expired, Marshallese (and other) COFA Migrants had their Medicaid rights removed. As we see now with the Marshallese population in Springdale, this right is invaluable to them, and they are physically suffering without it. In this situation, we can see the clear power disparity between the US and the RMI. The US removed Medicaid eligibility from Marshallese COFA migrants, but it would be

inconceivable if the RMI removed certain COFA privileges from the US. For instance, the RMI could not have simply removed the US military's right to occupy and operate their invaluable Reagan Missile Test Site on Kwajalein Island. Quijano's coloniality of power is clearly evident here: although the relationship between the RMI and the US officially changed from the US' dominion over the Marshalls as a UN Trust Territory Administrator to a Free Association between two sovereign states, the continuing superiority of power—a product of the colonial UN Trust Territory relationship—remains with the US.

The structural violence maintained by the US over the RMI is visible in this removal of major items from the COFA. Medicaid is a service for the poor and marginalized. The Marshall Islands remained economically poor and dependent, even though the US accepted the UN mandate and responsibility to prepare the nation for economic self-sufficiency as one of its Trust Territories. Economic development and prosperity cannot be forced, and it is unsurprising that the small, isolated, and resource-poor Marshall Islands did not strongly enter the world economy in its short time as a Trust Territory. However, by taking a neoliberal stance to social services and by trying to save money, the US only further marginalized the Marshallese in the States as they lost their access to such valuable social services. Without public aid for health and food, the Springdale Marshallese community's health suffers, as does their wallets. This is only one of a number of structural social determinants of health, others being language barriers, lower education levels, and their low socioeconomic class. As with other immigrant communities and ethnic and socioeconomic minorities in the US, social

mobility to leave the margins is difficult to achieve without public assistance. This is especially true for those without the ability to vote on the policies and laws that affect them.

Health as a Reason for Immigration

After employment prospects, which is discussed in the previous chapter, health is the key reason Marshallese leave the RMI for the US. The Marshall Islands faces many health challenges, such as high rates of obesity and cancer, a lack of specialty medical services, and the world's third highest prevalence of diabetes (34.9% of Marshallese between ages 20-79 have type 2 diabetes), among other noncommunicable diseases (Ichiho *et al.* 2013; Guariguata *et al.* 2013, 33). Other health issues include Hansen's Disease and other skin conditions, obesity, and cancer. There are public hospitals on the main population centers, Ebeye and Majuro, as well as small clinics on other islands. However, there are very few doctors, and the hospitals lack funding and current equipment.

I witnessed this when I flew to Majuro this summer for part of my internship. I accompanied a team of orthopedic surgeons from the US, and the very first surgery they performed was on a boy who had broken his elbow. He had a compound supracondylar humerus fracture—a complicated broken elbow, with the bone protruding through his skin. The remarkable thing is that he was only 6 years old, and he had suffered this break, untreated except for a sling jerry-built from a torn T-shirt, for two weeks. It is possible that if the orthopedic surgery team had not arrived, his arm would have never healed—he essentially would have died of infection from a perpetually open wound. In the US, this

type of break is considered an emergency, warranting correction within 24 hours. On Majuro, they don't have the resources or training to handle many medical issues.

Consul General Carmen told me she came to the US after a miscarriage. “For us—for Charlie and I—the reason that move us from the Marshall Islands was health. I got pregnant ... and we lost our first one. When we got pregnant again, then everyone told us, ‘Go, go to Hawaii, so you can get better health care.’”⁴¹ She lived in Hawaii and Missouri before coming to Springdale, where she hoped to get better prenatal healthcare. She admits that the prospect of better healthcare drove her to move. Majuro, where she was living, simply didn't have the quality of care she needed. “If it wasn't for that, I can see that we still would have been there, in the Marshall Islands, working. And others have different reasons, but that was our reason.”⁴²

Marshallese COFA migrants know that the United States has great medical facilities and health professionals. Calvin summed it up: “And for the hospital and clinic and like that, they have more than we have in the islands.”⁴³ He recognizes, however, that the Marshallese hospital staff work hard with what they have: “And I do appreciate our local medical doctors or staff in the hospitals, because they don't have what the other doctors and people are using in the States. But they are thinking, you know. They use their brain and try to diagnose.”⁴⁴ He laughed, then, at the ridiculous disparity between hospitals in the US and RMI.

⁴¹ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

⁴² Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

⁴³ Calvin, interview with author. September 8, 2014. Transcript.

⁴⁴ Calvin, interview with author. September 8, 2014. Transcript.

As I point out in Chapter 1, the US occupation of the Marshall Islands has been a heavy hand in determining the country's health and economic situations. The effects of this occupation and of the continuing colonial relationship between the two countries have rippled through time and space (affecting, as I posit in this thesis, the health of Marshallese in Springdale, Arkansas) and cannot be reversed.

Despite such the presence of good health care, many Springdale Marshallese lament the poor health insurance system in the US, which is particularly hard on them. Additionally, health expenses—even for those with health insurance—is far more expensive than the \$5 flat fee that Marshallese on Majuro, the capital island, pay for any procedure or visit at the public hospital. Older Marshallese, in particular, face health challenges, as they have worse health conditions but are often too old to be a part of the workforce to receive health insurance through full time employment. These will be discussed in further detail below.

Health Patterns and Barriers of Marshallese in the United States

Patterns of Health in the Springdale Marshallese Community

It is essential to explore the health of the Springdale Marshallese after immigration to the United States. By looking at the state of health of Marshallese in Springdale, as well as the barriers they face, we can trace these barriers' causes back to the US-RMI colonial relationship. Health was the most emotional topic of conversation that came up during my interviews in Springdale.

Aaron complained to me how unfair the Marshallese situation was. “We got nothing to help us,” he said. “Our elder are dying. You will see a lot of Marshallese are

dying here because they don't have any insurance."⁴⁵ Manuel had the same grievance: "I've seen a lot of people who are dying from cancer. I think they can be cured, they can take care of them, but because there is no health insurance, I think the health providers give up on them. There's no money to make out of them."⁴⁶ He teared up at his point and then proceeded to list cancer cases he had seen while working in hospitals in Wisconsin and Arizona. He said that patients who are in far worse condition than the Marshallese in Springdale are treated, but the Marshallese community in Arkansas is turned away and told their cases are too advanced to be treated, though in reality this denial is the result of a lack of health insurance. We will revisit the subject of cancer in Marshallese below. Important here is Manuel's assertion that without health insurance, Marshallese are dying because they cannot get healthcare.

Both Aaron and Manuel are well-involved in the community. Aaron is a community organizer who grew up in Springdale and devotes his time to working with the Marshallese population, and Manuel is a chaplain at Tyson Foods during the week and a church pastor on weekends. His whole job centers around knowing and working with the Marshallese community in Springdale. Both of them also mentioned insurance, or rather a lack of it, as a barrier to securing treatment—as a barrier to life.

Type 2 diabetes mellitus is the most recognized problem afflicting the Marshallese population in Springdale. Everyone I interviewed identified it as a pressing issue. Carmen told me, "It is like everyone in the household has diabetes ... I haven't seen a family that

⁴⁵ Aaron, interview with author. September 9, 2014. Transcript.

⁴⁶ Manuel, interview with author. September 8, 2014. Transcript.

doesn't have one diabetic."⁴⁷ One study of Marshallese migrants in the US found that "Their [Marshallese migrants'] health is reflective of the current health status on the Marshall Islands" (Williams and Hampton 2005, 318). Simply put, the health of the Marshallese in the US is similar to the health of the Marshallese in the Marshall Islands. This suggests that the outrageous rates of diabetes found in Marshallese in the RMI is similar to the prevalence among Marshallese in the US.

Most Marshallese agree that poor diet and lifestyle are the reasons for such a high prevalence, which resonates with the research I've done on noncommunicable diseases in the Marshall Islands (Ichiho *et al.* 2013; Reddy *et al.* 2009). Carmen told me, "There have been quite a few studies on our health, on the community's health. From the studies, they've discovered that our folks have diabetes, all the illness that comes from uncontrolled diabetes." The primary reason for this is the sudden change in diet from native produce and fish to heavily processed foods after World War II. "Over the years, people were cultivating the land and going out. They don't have any refrigerator to freeze things up."⁴⁸ Carmen told me that the generations before hers ate the foods they cultivated, and both the diet and the physical activity to secure that diet kept them healthy. Carmen is diabetic.

Aaron said the same thing. "Because the food they [Marshallese] eat now are Western food. But back then, they eat their own food. They work for it. But when the canned food was brought to the islands, they got crazy about it. Eat eat eat eat eat. They

⁴⁷ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

⁴⁸ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

get a lot of these diseases that we did not know about.”⁴⁹ Manuel’s explanation was almost the same as Aaron’s: “We do not plant our own crops and stuff, and I think that’s also a main thing. We put the chemicals in the food, and our bodies are not absorbable to eat that kind of stuff.”⁵⁰ Marshallese used to grow and eat native produce, such as taro, pandanus and coconut. They supplemented this produce with fish. These foods are natural, high in fiber, and low in sugar—a diet fit to keep blood sugar levels low. The nutrition transition from these foods to sugary foods with little fiber was a drastic reversal in diet (Ichiho *et al.* 2013).

The staggering prevalence for diabetes begs the question: what other factors lead to the disease? The Marshall Islands has the third highest prevalence for diabetes out of all nations. Is that really due to just lifestyle and diet? Carmen let slip her emotional investment in this disease that afflicts her and so many other Marshallese.

But how much more is from the change of the way of living? ... I wonder what is different about our immune system from yours and the rest of the American people? Or is it the same? Or us to the Indians in this country? Because it’s like we have a lot of people with diabetes ... The Japanese, for example, I hear that they eat rice in the morning, in the afternoon, and for dinner. They eat rice every meal. But they don’t have as many diabetics as us.⁵¹

Her passionate tirade wasn’t directed at me so much as it was toward fate, toward the inevitable and seemingly hopeless condition the Marshallese face in Springdale and in the Islands. Carmen believed there was a physiological reason for this prevalence of diabetes,

⁴⁹ Aaron, interview with author. September 9, 2014. Transcript.

⁵⁰ Manuel, interview with author. September 8, 2014. Transcript.

⁵¹ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

that something in Marshallese genetics made them more susceptible to the disease than others. I told her about the Tohono O’odham, a group of Native Americans who, at one point, on a local level, had the world’s highest prevalence for type 2 diabetes—the result of an almost instant diet switch from traditional and self-harvested foods to processed and packaged foods (Fazzino II 2010). This was, I said, an exaggerated example of what the Marshallese went through.

Calvin pointed to the diet habits of Marshallese living in specifically in the US. “Well, the Marshallese like cola,” he laughed. “And they eat food ... We like rice and chicken. We come here [to Springdale], it is more chicken, you know! Cholesterol like that is supporting our problem, kidney problem. I think it’s lifestyle.”⁵² The habits he mention are the same ones that emerged in the RMI after militarization. They are consistent with my observations on food at Marshallese parties I attended in the RMI and in Springdale. Calvin is a big advocate for healthy lifestyle, and he prides himself on being more fit and younger looking than most other Marshallese his age. Calvin is 66, and he said few Marshallese live into their 70s (Ichiho *et al.* 2013, Table 1). “Many people around here, they are younger than me,” he informed me. “But they look like they are older. Because of diabetes.”⁵³

Despite being such an advocate for healthy dieting—going so far as to voluntarily manage the Springdale SDA School’s greenhouses out of a belief in eating mostly produce—Calvin has type 2 diabetes. His wife does as well, and their adopted son who

⁵² Calvin, interview with author. September 8, 2014. Transcript.

⁵³ Calvin, interview with author. September 8, 2014. Transcript.

lives with them is obese, which is a known risk factor for diabetes (Ganz *et al.* 2014, 3). They fed me in their home frequently during my stay in Arkansas. Every meal they served me centered around chicken and rice and had little fresh produce. Their diet was largely dictated by income: Calvin's wife purchases chicken at work, where she gets the Tyson employee discount. The rest of their meal consists of homegrown tomatoes and whatever food is gifted to them by church-run food banks: non-perishable food items, many of which are merely microwaved or fried until table-ready. Calvin's household is a meager four people, with one working; most Marshallese households have far more residents.⁵⁴ From what both Marshallese and non-Marshallese told me through interviews, it is highly likely that low income influences the high rate of diabetes among Marshallese: Marshallese have little money, poor budgeting skills, and high and frequent unemployment.⁵⁵ Thus, one reason Marshallese have high rates of diabetes—a disease of the poor (Levine 2011; Hyman 2010)—is because they have less economic means. In addition to being more expensive, sometimes, nutritious foods are often found in grocery stores located further away from low-income neighborhoods.

⁵⁴ The 2005 Williams and Hampton study on health barriers to Marshallese living in northwest Arkansas found an average of seven people per Marshallese household in Arkansas (Williams and Hampton 2005, 318). They also found that Marshallese women in Arkansas had an average of 5.4 children (Williams and Hampton 2005, 318). However, qualitative data from my interviews with both Marshallese and non-Marshallese residents in Springdale suggests these numbers are even higher. Underreporting could be due to a mistrust of non-Marshallese or fear of citation from breaking housing codes, both of which were stated by Marshallese and non-Marshallese as barriers to accurate census counts.

⁵⁵ Budgeting problems was an issue brought up without prompting by both Marshallese and non-Marshallese during interviews in Springdale. How this notion of Marshallese and budgeting problems originated is not clear. Its ubiquitous association makes it an ethnic stigma. The Marshallese community in Springdale may say this is a problem because others outside of the community have previously said it was.

Other health problems affecting the Springdale Marshallese population more than normal include tuberculosis (TB), a lack of immunizations in children, and Hansen's Disease and other uncommon skin conditions. From a public health point of view, TB was what put Marshallese on the map in Arkansas. During the early 2000s, when there was a particularly large influx of Marshallese, Springdale city health workers started noticing a growing outbreak of TB. They discovered that many of the cases originated with recent Marshallese COFA migrants.

As Springdale began addressing TB in the Marshallese population, they uncovered other public health issues: a lack of immunizations, overcrowded living spaces, and Hansen's Disease (also known as leprosy). Hansen's Disease was a particularly loud red flag for the city, because it is rarely found in the US. In fact, more cases of Hansen's are found in Marshallese than in any other demographic in the US, likely because the FSM and the RMI together have the highest prevalence for Hansen's Disease in the world (Cairns, Jr. 2008, 5; Woodall *et al.* 2011, 1202). One study on Hansen's Disease listed that 13% of all US cases of Hansen's Disease from 2004-2011 were found in COFA migrants from the FSM and RMI—a notable figure, considering how relatively few there are in the US (Woodall *et al.* 2011, 1202). Leprosy is a bacterial disease, and it is most often found in tropical climates where there is overcrowding, poor hygiene, and poverty (Accorsi *et al.* 2009). These conditions are found in Majuro and Ebeye, the two population centers of the Marshall Islands. The slum conditions on Ebeye (overcrowding, poor hygiene, and poverty—Hansen's Disease' ideal environment) are a result of the US militarization of nearby Kwajalein Island. The fact that one of the rarest

diseases in the US is found in its Marshallese community is one of many shows of disparity between the RMI and the US, despite their “free association.”

It’s important to note that some smaller minorities in Springdale suffer almost the same set of diseases as the Marshallese. “But I have not just Marshallese,” Sadie told me, “I have Pohnpeians and Chuuks, also, in my Hansen’s program.”⁵⁶ Although set up to serve the Marshallese and Latino populations in Northwest Arkansas, the Bates Outreach Clinic where Sadie works finds itself servicing some COFA migrants from a country besides the RMI. While there are far fewer of these ethnic minorities in Springdale, they are in a similar situation as the Marshallese: Pohnpeians and Chuukese are from the Federated States of Micronesia (FSM), one of two other COFA states beside the RMI. The FSM and the RMI occupy the same area of the world and face similar economic and health challenges. The Federated States of Micronesia, for example, barely edge out the Marshall Islands as having the world’s second highest prevalence for diabetes (Guariguata *et al.* 2013, 33).

The levels of both Hansen’s Disease and TB in the Springdale Marshallese population have dropped dramatically since Sadie and the tiny Jones clinic began working closely with the community. One prevalent disease that is poorly addressed in the Marshallese population is cancer. There are many cases of cancer—mostly thyroid—but there is no available data on the issue. Manuel believes that these cancers might be the result of residual radiation or altered genetics as a result of the US nuclear weapons tests done in the Marshall Islands during the Cold War.

⁵⁶ Sadie, interview with author. September 11, 2014. Transcript.

I have neither the expertise nor the data to say if this is the case, but the assertion has grounding. The infamous Castle Bravo nuclear weapon test in 1954, for example, resulted in an explosion greater than expected. It detonated with a force 1,000 times more powerful than the atomic bombs the US dropped on Hiroshima and Nagasaki toward the end of World War II (Westcott 2014, n. pag.). The resulting mushroom cloud contaminated over 7,000 square miles of ocean, including three inhabited atolls in the Marshall Islands: Rongerik, Utirik, and Rongelap. Marshallese from these atolls came down with severe symptoms of radiation poisoning, and many died of thyroid cancers, miscarried, or birthed severely deformed babies (Brown 2013, 30; Cronkite *et al.* 1954). United States military personnel in the area also suffered ill health effects afterward. The US claims the contamination of inhabited atolls was an accident. Many Marshallese officials claim it was intentional. Whichever it was, the health effects were devastating, and the US spent years documenting these as part of the recently declassified Project 4.1 (Cronkite *et al.* 1954). All of this happened while the Marshall Islands were still a United Nations Trust Territory being administered by the United States. Irradiating a country's people and lands is a poor way to prepare a state for independence.

Again, this is an example of how structural power—the US administering the Marshall islands—can create global health issues at a scale impossible to achieve by the actions of individuals. We also see how this structural violence through the US's continuing colonial relationship with the RMI affects the health of the Marshallese in the US even today.

Barriers to Health in the Springdale Marshallese Community

One of the most visible barriers the Springdale Marshallese face in health is language. “Communicating that is difficult when you have the language barrier,” Mayor Doug Sprouse said. “Hispanic—Latino—there’s a language barrier there, but it’s not nearly the language barrier as the Marshallese.”⁵⁷ He first brought it up as a barrier to integration as a whole in Springdale. The language barrier between Marshallese and non-Marshallese can lead to serious problems, at times. Sadie, from her position as a public health nurse, acknowledges the problem. “Language is a huge barrier. It’s very difficult to translate.”⁵⁸ This language barrier makes patient-doctor interactions difficult. It also complicates the already-complicated healthcare system. Mary, who is the health coordinator for the Springdale School District, said, “There is a very low level of health literacy and how to navigate the healthcare system.”⁵⁹

Mayor Sprouse is large and friendly, and he believes the city of Springdale and its citizens are the finest in Arkansas. He speaks fast, but not to mislead, and he loves telling stories. His eyes are friendly and his hands powerful, when shaking yours. His familiarity with the Marshallese community in Springdale began when he served on the Springdale School District board. While there, the big influx of Marshallese in 2000 happened, and Springdale schools saw spikes in the Marshallese student population.

The language barrier also has indirect consequences on health. The biggest of these is the difficulty in getting a driver’s license. Aaron, Doug, Calvin, and Sadie all brought this up. Sadie clearly named this difficulty a public health issue: “Transportation

⁵⁷ Mayor Doug Sprouse , interview with author. September 11, 2014. Transcript.

⁵⁸ Sadie, interview with author. September 11, 2014. Transcript.

⁵⁹ Mary Miller, phone interview with author. September 11, 2014.

is a huge huge huge huge barrier. You heard us talking, briefly, about the driver's test.

That is a public health issue. How can you drive around if you don't know the rules of the road?"⁶⁰ There are no political-legal barriers to Marshallese COFA migrants obtaining an Arkansas driver's license. The test is not offered in Marshallese, however, making it very difficult for many Marshallese COFA migrants who don't know or have trouble with English to obtain a driver's license. Thirty days after arriving in Arkansas, Marshallese driver's licenses become invalid and must be replaced with Arkansas state driver's licenses (Williams and Hampton 2005, 324).

Doug brought up driver's licenses as a Marshallese culture problem, rather than a structural one: "Again, the consulate is so important in this process. In trying to help them understand the need for driver's licenses, for insurance."⁶¹ Doug was implying that Marshallese don't get driver's licenses because they don't see the need to. This perspective differs from that of the Marshallese, who say that Marshallese drivers clearly want to take the test to receive their licenses—they just cannot.

The health effects of not having a driver's license are numerous. Besides the inconveniences of possible racial profiling (Aaron believes this happens; Sadie acknowledges it is a possibility), not having a driver's license leads to the inability to get to work on time (and thus keep a job and its health benefits) or to get to the hospital with ease. Additionally, Marshallese who are cited for driving without a license spend valuable

⁶⁰ Sadie, interview with author. September 11, 2014. Transcript.

⁶¹ Mayor Doug Sprouse, interview with author. September 11, 2014. Transcript.

time and money on tickets and court appearances, when that money could be used to make a hospital co-pay or purchase prescription medicines.

Money issues, in general, are a barrier to health. Sadie put it simply during our interview: “There are financial barriers, that they are incredible poor ... they are absolutely struggling.”⁶² The most recent study I could find on the income of Marshallese COFA migrants was completed in 2002, and it listed a per capita income of \$6,691 among Marshallese living in Arkansas—well below the US poverty line (Spenneman 2002, n. pag.). As I covered in the section on domestic migration in the previous chapter, it is common for Marshallese employees to be fired for missing work repeatedly. Without a steady income or health benefits, healthcare in the US is difficult to afford. Manuel, who works with struggling Marshallese through his job at Tyson, says losing a job isn’t seen as an immediate crisis. “Well, Marshallese are like extended family ... ‘If I don’t go to work, I don’t care, because you will take care of the bills.’ I think that’s one of the main things—they don’t care about who’s going to work to pay the bills.”⁶³ Sadie told me that even those with insurance have difficulty affording care. She said that after paying the household’s bills, feeding those in the household who don’t work, and making a vehicle payment, Marshallese often don’t have enough cash left for a hospital visit copay or pharmaceuticals. “So the insurance is wonderful if you have the money to use the insurance that’s supposed to save you money.”⁶⁴ Once again, the socioeconomic barrier

⁶² Sadie, interview with author. September 11, 2014. Transcript.

⁶³ Manuel, interview with author. September 8, 2014. Transcript.

⁶⁴ Sadie, interview with author. September 11, 2014. Transcript.

of low income makes access to healthcare difficult even for Springdale Marshallese who have health insurance.

After housing, Dawn thinks one of the biggest expenses is cars. Her husband has access to financial records of many Marshallese through his job at Tyson Foods, so she says she knows some general patterns. “Just looking at them—the majority of the things that they’ll spend money on is cars. Because they have a very hard time getting low interest rates. Lack of credit ... they’re paying 10, 12 percent interest.” Her conclusion: “I think they would benefit from someone teaching the basic financial counseling.”⁶⁵

This idea of the need for financial literacy among Springdale Marshallese came up frequently. On a short drive through town, Calvin told me that Marshallese didn’t budget well. He said that Marshallese like to spend money, especially when they have so much more than they did in the RMI. Unfortunately, this money is often spent like disposable income: on beer and gambling. Calvin’s perspective could be influenced by his religious beliefs—gambling and drinking are activities he doesn’t engage in. But his story matches others’. Sadie told me, flatly, “They don’t budget. They don’t understand how to balance a budget. Budgeting is a new concept.”⁶⁶ She thinks this is because they had little money in the Marshall Islands, and because they had different expenses there—many utilities or major payments in the States were provided or available at no cost in the Islands. Manuel complained about this, too. “Our problem here with the Marshallese: we don’t know how to manage our money. We never have that kind of money before. You

⁶⁵ Dawn, interview with author. September 12, 2014. Transcript.

⁶⁶ Sadie, interview with author. September 11, 2014. Transcript.

guys—you grow up using money from when you are little. We came and even during income tax, in one month we can have six or seven thousand, and in a couple weeks or a month, it's already gone. That's one of the problems. Someone should teach these people money management.”⁶⁷ His frustration with his community stems from the fact that his whole job is to help them. He wants to see them succeed. More data is needed on this topic for an accurate assessment of the situation to be made, but the agreement by Marshallese and non-Marshallese that this is a problem shows that it likely is.

This money barrier can be linked to a continuing structural violence in a number of ways. As Manuel pointed out, the poor economy in the RMI means that most Marshallese have never handled so much money before working in the US—and they may not know how to best use that money in the US, where short-term financial decisions result in long-term effects—such as investing in a retirement account or establishing good credit. In this case, the state of the global economy limits financial education in the RMI, and the lack of government social services for Marshallese COFA migrants in Springdale force Marshallese to spend much of their limited incomes on food or healthcare that might otherwise be subsidized or free if they were US citizens.

⁶⁷ Manuel, interview with author. September 8, 2014. Transcript.

Another widely recognized barrier between Marshallese and health is the differing cultural notion of time.⁶⁸ I mention this in the previous chapter, in the section on domestic migration. Although multiple Marshallese told me about the community's habit of being late or untimely, only non-Marshallese health professionals connected this habit with public health. Sadie summed up the problem. "If you give a Marshallese person an appointment four months from now, they're not going to show up." Her solution? "When they're here, and they have a crisis, and they have an issue, you better get 'em in to the doctor in the next couple of days. Or else they're not going to go."⁶⁹ Dawn said that when Marshallese patients miss their appointments, as happens often, they know how to get treatment. "If they didn't make their appointment, they would just come in to the ER. 'Ah, no, we ca just get in anytime.'" The problem with this is the expense: "A lot of times, if they don't have insurance, it's not covered. Thy end up in extreme debt, which is a huge problem for someone who is not making a huge amount to money to begin with."⁷⁰ One of the reasons Marshallese don't make their appointments is because they often don't see the need—they may not feel sick, and don't see the need for medical care. This is yet another barrier to health.

⁶⁸ While both Marshallese and non-Marshallese brought this up, it is important to note where this idea came from. The phrase "Marshallese time" is used by Marshallese in Springdale, but such a phrase could only be created in opposition to something else, another idea or phrase. The "Marshallese" in "Marshallese time" is added to set this idea apart from other notions of time (in this case, "Western" time). This suggests that the idea of Marshallese time came from non-Marshallese persons who named it as such. Considering the Western work ethic, where busyness is considered an economic and social status value, Marshallese time is considered inferior, a problem getting in the way of work, education, and even celebrations. It is a stigma, even if the Marshallese say it about themselves.

⁶⁹ Sadie, interview with author. September 11, 2014. Transcript.

⁷⁰ Dawn, interview with author. September 12, 2014. Transcript.

This brings up another health barrier: a perceived general lack of health maintenance. Marshallese in Springdale tend to visit the doctor only when they're very sick. This was pointed out by both Marshallese and non-Marshallese in Springdale.

Carmen said it like this:

Our problem is that we don't have—it's just like in the Marshall Islands—we just have that primary help. When we're sick, we go see the doctor. When we come here, that's one challenge that we face. We cannot really go through this 'maintenance mode' ... They [US hospitals and clinics] want to take care of you and go through that process of maintaining. That's a challenge for us, because we do not.⁷¹

She attributes this health pattern to recent changes in Marshallese culture and tradition.

“Maybe our elders did that maintenance, because they did their rituals, but that is not happening to us nowadays because of changes in life and way of living ... We don't have that structure anymore. I believe that we had maintenance concept, but nowadays it's different ... Only when we're really sick we will see the doctor.”⁷² One research study on the health practices of Marshallese COFA migrants in Hawaii points this out as a major finding: “Marshallese migrants do not seek health care until they perceive a health crisis, usually indicated by pain. This cultural notion of ‘present crisis-oriented health care’ governs overall health care behaviors of Marshallese migrants” (Choi 2008, 73). This finding also complements the findings of the 2005 study of Marshallese-perceived health barriers for Marshallese in the US (Williams and Hampton 2005, 323).

Dawn confirms this habit from her emergency room management perspective.

“The problem is, they generally will not come in until they're very very sick ... it's,

⁷¹ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

⁷² Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

they're about to die when they come in, basically. And part of that is—in my opinion—is lack of preventative medicine.” She said that the chronic health conditions the Marshallese face require regular, timely appointments. Missing these is harmful to their wallets and their health. She recognizes the problem in the Marshallese community in northwest Arkansas, but is hesitant to name it as such: “I don’t know if that’s a culture thing.”⁷³

Sadie has a strong opinion on the origins of this health habit. She links it to a lack of quality sciences education in the Marshall Islands.

In the Marshall Islands, there is not a strong science program. All of this starts with education. If you’re on the outer islands, you’re not really forced to go to school ... They didn’t get it [education in science] in grade school, they may not have much of it in high school, a lot of people that live in this area—these are adults that didn’t go to school at all ... And they have no science background, so even the idea of germ theory, which we teach in Kindergarten, is a foreign concept to a lot of them. If you don’t have strong science background, you don’t understand how the body works. You don’t understand what makes medication work. And if you can’t see it, you’re not really sick.⁷⁴

Sadie said this is particularly harmful when it comes to diabetes. It’s difficult to link specific symptoms with diet without a basic understanding of the body. For example, it’s not intuitive to link glaucoma with drinking sugary beverages. Underfunded education in the RMI is a result of having little money from a poor economy. Although it is a lengthy chain, Sadie is tracing, here, the structural violence caused by a lack of promised economic assistance to the RMI from the US, through underfunded education, though a

⁷³ Dawn, interview with author. September 12, 2014. Transcript.

⁷⁴ Sadie, interview with author. September 11, 2014. Transcript.

lack of understanding of modern medicine and health, through health barriers the Marshallese in Springdale face today.

In addition to “Marshallese time,” as they call it, and a lack of basic science knowledge, this reluctance to visit the hospital regularly may also be influenced by the aforementioned financial problems. Is it worth paying to see a doctor if you’re feeling well?

Because of the tight-knit nature of Marshallese families (and the Marshallese community, as a whole), one patient’s hospital appointment is often a family affair. Dawn has seen this often in her time working at hospitals in Northwest Arkansas. “Everything they do is based on family. They usually don’t come in [to the hospital] by themselves. They come in with a whole entire group of people with them.” She gave a reason for this practice: “They want to make sure that there’s someone else with them so they can always get a group understanding. If they are a patient in the emergency department when they are ill, they always have a spokesperson that speaks for them, that makes healthcare decisions. It may not be an immediate family person, but they always have a person that speaks for them in the family.”⁷⁵ Having a health spokesperson, as Dawn says, or multiple family members present during hospital visits could be a way to overcome language barriers, get second opinions on health matters, and to assist in navigating the healthcare system. It could also be for trust reasons. Aaron told me flatly that in many cases, “Marshallese don’t trust those who aren’t Marshallese, even if they wear a sign

⁷⁵ Dawn, interview with author. September 12, 2014. Transcript.

saying ‘We are helping Marshallese.’”⁷⁶ Some Marshallese I spoke with suggested that mistrust of non-Marshallese (specifically, US citizens) stems from the destruction caused by the nuclear weapons tests conducted by the US in the Marshall Islands during the Cold War. If so, this is just one more barrier to health caused by the structural violence maintained by the US over the RMI. Of course this practice could merely be because the Marshallese are community-oriented. After all, bringing family members to hospital visits is not uncommon in the States.

The reason this is important to address is because, as Sadie told me, “They [Marshallese patients] don’t get good representation at the doctors.”⁷⁷ As a health professional who works with Marshallese, she doesn’t believe they are getting as much out of their hospital visits as they should be. She also brought up the trend of Marshallese patients visiting clinics in groups, but she thinks it is primarily to overcome language barriers. “They tend to tell their problems to one of their family members or somebody they choose to speak for ‘em, so when they go to the doctor, the person that they told that to is supposed to be talking for them,” Sadie told me. Dawn said almost the same thing about these family healthcare spokespersons. “They will look to someone else to make their healthcare decisions.”⁷⁸ Accompanying family members act as translators and family healthcare decision-makers. Dawn told me that these decision makers aren’t determined by age, but by how long they’ve lived in the US. Those who have lived in the States longer have a better grasp on the region’s healthcare system, and help to

⁷⁶ Aaron, interview with author. September 9, 2014. Transcript.

⁷⁷ Sadie, interview with author. September 11, 2014. Transcript.

⁷⁸ Dawn, interview with author. September 12, 2014. Transcript.

acclimatize the most recently arrived family member. Patient-doctor interactions could be improved with this knowledge, especially in light of patient privacy laws, which may be detrimental to Marshallese patients in the US.

If someone is sitting in on a private appointment, Dawn told me, doctors would like them to be close family. She also said that the complex nature of Marshallese relationships makes this closeness difficult to determine—seemingly all Marshallese are related somehow, and the definitions for terms like “sister” or “aunt” do not necessarily agree between Marshallese patients and US health professionals. Sadie told me that this is the case, and that sometimes doctors, “well, they’ll run that person [family member] out of the room.” With their trusted health spokesperson and translator gone, the effectiveness of a hospital visit plummets. In particular, Sadie said, Marshallese patients who speak little English will politely answer ‘yes’ to all questions, regardless of their actual understanding of the words being spoken. “And then here’s your little client, sitting there: ‘yes.’ Won’t tell them what’s wrong. So that’s a big barrier to them getting good health care.”⁷⁹ Without their health spokesperson or translator present, Marshallese may get poor health assistance during hospital or clinic visits.

The structural violence over the Marshallese in this case is less clear. It is a negligence on the US’ part by not understanding and addressing the Marshallese unique health habits and needs. The reason this is negligence and not just an understandable inability to address a unique and specific challenge is because the terms of the COFA all but invite Marshallese to come to the US. At the same time, the COFA terms, amended by

⁷⁹ Sadie, interview with author. September 11, 2014. Transcript.

Welfare Reform in 1996, constrain Marshallese COFA migrants' access to desperately needed social health services.

Health Advocates for Marshallese in Springdale

Although the Springdale Marshallese face many health challenges, there are organizations and programs working to help the community. Such a large population can't go unnoticed. The primary entity working for the Marshallese is, unsurprisingly, the RMI Consulate in Springdale. Consul General Carmen was crucial in starting it, and she has headed it since its inception in 2009. Hospitals and the government have both found the consulate to be the best method of disseminating information to the Marshallese population. In addition to being a resource for legal and practical information for the Springdale Marshallese, the Consulate has prudently reached out to the Marshall Islands, priming Marshallese COFA migrants on laws and tips for life in Springdale.

Marshallese churches have also been a health resource for the Marshallese, using their most valuable characteristic—providing space for groups of Marshallese to gather—as a way to more efficiently give health lectures and information. The Northwest Arkansas Workers' Justice Center, and Aaron in particular, as their Marshallese community organizer, has also been helpful in dealing with occasional health problems related to the workplace. The Springdale School District is already hiring translators and opening school health clinics, largely in response to the significant Marshallese student population. Up and coming organizations include the recently started Marshallese Education Initiative, a Springdale-based organization working to help Marshallese with

education issues, and a fledgling all-Marshallese-run nonprofit being started by the single Marshallese court translator in the US.

One of the larger health advocates for the Marshallese community in Springdale is the Dr. Joseph H. Bates Outreach Clinic, which began work with the Marshallese in 2000 and opened its tiny brick and mortar doors in 2010. This history gives them more time with the Marshallese than even the RMI Consulate, and longtime advocates like Sadie have earned them a credibility and closeness with the Marshallese, as well as a comprehensive understanding of the community and its health issues. The clinic also provides services for a sliding fee scale, meaning that Marshallese who really can't afford to pay for treatment get it for free or at extremely low cost—a crucial service for low-income Marshallese families. The Bates Clinic is an example of private organizations stepping in to fill what some might consider to be the role of public social services.

The upcoming UAMS northwest Arkansas Marshallese community health study has the potential to be a big advocate for Springdale Marshallese. As far as Pearl, its director, knows, this is the biggest, highest-funded research on a specific Marshallese health problem ever. The scale of this 3-year community-based study far outstrips the Bates Clinic's staffing and funding, and both the research and the attention could go a long way in bringing wider attention and desperately needed rigorous hard data to the Marshallese' health condition in Arkansas.

But the biggest potential health asset the Marshallese have are themselves. Their extremely tight-knit community is a structure that is and can be further used to assist those who have the most need (health, financial, etc.). This community is one that crosses

state and country borders, as we see with the fluidity of family, remittances, and the purchasing of one-way plane tickets for Marshallese overseas to join family in Springdale. The power of this familial community is apparent in aspects such as Springdale's homeless rate, which in 2011 did not even acknowledge Marshallese as a demographic of the homeless population (Fitzpatrick 2011). Manuel, whose church does homeless outreach, told me this was because there *were* no homeless Marshallese in Springdale. "I only see white people who are homeless. Marshallese—I think because, as I said earlier, they have extended family—they take care of each other."⁸⁰ Marshallese COFA migrants, who come from an economically disadvantaged background and face barriers of language and education, among many others, have far less (perhaps none) homeless than all other races in Springdale, likely due to the close community.⁸¹ Aaron told me, proudly, "Everywhere you go, you have family. You will not get lost. You will not get hungry. You will not need anything. Because they will be there to help you out."⁸²

Looking to the future, the Marshallese I interviewed had a universal hope in the up and coming generation, those Marshallese that were born and raised in the US. Since so many Marshallese youth have US citizenship, they provide their family relief through eligibility for the United States Department of Agriculture's Supplemental Nutrition Assistance Program (SNAP), Medicaid's Children's Health Insurance Program (CHIP), and other benefits denied Marshallese COFA migrants. By receiving food aid through

⁸⁰ Manuel, interview with author. September 8, 2014. Transcript.

⁸¹ To be transparent, I want to point out that in Hawaii, this situation is far different. Many Marshallese are homeless in Hawaii, due to many potential factors: strong systemic racism, active government discrimination, and high cost of living (Carucci 2012).

⁸² Aaron, interview with author. September 9, 2014. Transcript.

SNAP, or free healthcare through CHIP, they are saving their families from having to pay for these services or goods. These immediate benefits provide food and health benefits to low-income Marshallese families, but the real hope is when the majority of Marshallese youth (who are US citizens) begin to turn 18.

Aaron said, “The younger generation—they will have an impact on the community if they step it up right now. A lot of them turn 18.” Although he came to the US as a child, Aaron doesn’t have US citizenship. He is in the process of obtaining citizenship, although he’s dismayed at how complex and arduous the path to citizenship is. But many Marshallese in Springdale who aren’t much younger than him were born in the US and have citizenship. Growing up in the US, they have seen what the Marshallese face compared to non-Marshallese in Springdale. “Maybe one day their brain will open and pow! ‘My people are struggling over here. What do I need to do?’ When one starts it, everyone will follow.”⁸³ More than merely growing up as a Marshallese with US citizenship, that very citizenship gives the next generation of Marshallese the tool that Springdale Marshallese believe will give them a voice in the US: the ability to vote.

Aaron thinks this will come sooner rather than later. “I believe two years from now, you will see, thousands of Marshallese are registered to vote. They [non-Marshallese] will go, ‘Oh! Marshallese!’”⁸⁴ Manuel believes this change will happen soon, too. “I think a few years from now, they will listen to us, because our population who are citizen and was born here, there are more. They will likely vote, to hear our

⁸³ Aaron, interview with author. September 9, 2014. Transcript.

⁸⁴ Aaron, interview with author. September 9, 2014. Transcript.

voice.”⁸⁵ Calvin also sees the ability to vote as a means for change for the Marshallese, though he looks further into the future. “And I believe that 20 years from today, the Marshallese community will be really recognized from the US. Because of the kids who are born here.” He laughed as he told me this, but I don’t know why. “They’re growing up, there is more people. When there is time for vote, I think they’ll cash their vote. I’m looking to the future.” Despite the special considerations given to COFA migrants, they don’t have the ability to vote on US domestic matters. This is why the 1996 Welfare Reform bill so easily stripped them of the social service rights COFA promised them—they had no way to oppose it.

The prospect of hope in Marshallese with US citizenship is marked by a bittersweet revelation, however. In the eyes of most Marshallese COFA migrants in Springdale, the youngest generation of Springdale Marshallese sacrifices Marshallese culture in exchange for US citizenship. Many told me that they were disappointed that their children and grandchildren will never know what life in the Islands is like, that they speak Marshallese less, and that many cultural customs are being lost. Aaron generalized the different generations of Springdale Marshallese for me: “Our generation is really mixed now. The elder’s generation are really Marshallese. And my generation—we are half and half. The younger generation—they’re *really* Americanized.”⁸⁶ Springdale Marshallese take pride in their culture, and those I interviewed all expressed a yearning for their homes in the Marshall Islands. Language and knowledge of life and customs in

⁸⁵ Manuel, interview with author. September 8, 2014. Transcript.

⁸⁶ Aaron, interview with author. September 9, 2014. Transcript.

the Marshall Islands is perceived by older Marshallese as less important to younger Marshallese living in Springdale.

The changes the Springdale Marshallese want most of all is easier access to health insurance. This is chiefly eligibility for Medicaid in Springdale, which COFA migrants are unable to access, even if their income is not enough to make them eligible for subsidized health insurance through the Affordable Care Act. The second most wanted item surprised me by its relative paltriness: the option to take the Arkansas driver's license test in Marshallese. That shows just how big of a barrier to integration that is.

Conclusion

In this chapter, we explored the Compact of Free Association and its implications on Marshallese migrant status and eligibility for healthcare. The COFA grants the RMI financial aid and Marshallese travel and work privileges in the US while granting US exclusive military rights in the Marshall Islands. Under the COFA, Marshallese citizens living in the US are not recognized as immigrants, but as nonimmigrants without visas, or COFA migrants. This special status makes them ineligible for Medicaid (and other government social services) in Arkansas. Marshallese COFA migrants used to have this right, but it was removed from the COFA before it expired by US President Clinton's Welfare Reform bill in 1996, which sought to save money by cutting government spending on marginalized communities. This lack of Medicaid is a handicap for Marshallese COFA migrants in Springdale, who often can't afford other means of healthcare or health insurance.

We also discussed how health is a major reason for migration for Marshallese moving from the RMI to the US. Healthcare in the Marshall Islands is inexpensive for patients, but the country does not have adequate funding or personnel to give necessary care. Many come to the US to receive better healthcare, and the majority of Springdale Marshallese with health insurance receive it through a family member receiving family insurance coverage through full-time employment at Tyson Foods. Many do not have health insurance, however, and many who do are still unable to afford healthcare.

The health of Springdale Marshallese reflects the health of Marshallese in the RMI. The population has high rates of diabetes, cancer, and rare conditions like Hansen's Disease. Certain cultural health practices, such as relying on another family member to manage one's health or only seeking health when critically ill, are major barriers to achieving good health. Various structural barriers exist, too, such as an inability to take the Arkansas driver's license test in Marshallese, living with non-immediate family, language, a lack of strong science education, and the ineligibility for Medicaid.

Despite the poor health and multiple barriers facing Springdale Marshallese, the community has a few advocates, such as the Bates Family Clinic and the upcoming University of Arkansas health study.

Chapter 4

Conclusions and Recommendations

The long history between the United States and the Marshall Islands created the poor health conditions present in the Marshall Islands today. This happened through the displacement of Marshallese from their home islands for the sake of nuclear testing, subsequent overcrowding of other islands and the inability for subsistence agriculture, exposure to radiation through fallout from US nuclear tests and through consumption of irradiated foods, and the rapid nutrition transition following the introduction of canned and packaged foods. Now, the Marshall Islands has the world's third highest prevalence for diabetes, and suffers from numerous other noncommunicable diseases. The colonial relationship present when the Marshall Islands was under US administration as a UN Trust Territory of the Pacific continued even after independence, as the newly sovereign Republic of the Marshall Islands entered into a Compact of Free Association with the US in 1986. In return for considerable economic assistance and valuable migrant privileges, the RMI (along with the Federated States of Micronesia and later Palau, with their Compacts with the US) gave the US de facto strategic military control over the Pacific Ocean.

Taking advantage of their special migratory allowances, Marshallese have been steadily moving to the United States, pursuing better economic, health, and education prospects. Marshallese in Springdale find employment primarily in the region's large poultry industry, which conveniently provides employment and health insurance coverage to full time employees and their families. Springdale Marshallese face many barriers

common to immigrants in the US, but they sidestep a few of those as well, since they do not need visas or special permission to enter and work in the US.

This COFA migrant status—in itself, a mark of the colonial power the US has over the RMI—is a severe handicap toward getting health insurance, however, as it limits them from accessing certain health services in Arkansas. Their situation is complex. Marshallese COFA migrants are eligible to sign up for subsidized health insurance plans through the Affordable Care Act. Since the majority of Marshallese in Springdale fall below the poverty line, the Affordable Care Act removes them from the subsidized insurance bracket and places them in the Medicaid expansion bracket. Due to their COFA migrant status, they are not eligible for Medicaid expansion (in Arkansas), and thus are without affordable health insurance options. This lack of insurance for many non-working Marshallese, combined with severe health problems—some of which are rarely seen in the US—creates a situation of poor health for many Springdale Marshallese. Among the specific health problems acutely effecting the Springdale Marshallese are type 2 diabetes and skin conditions such as Hansen’s Disease, both of which can be traced back to the displacement, nutrition transition, and overcrowding caused by US occupation and military exercises in the Marshalls. Also prominent is thyroid cancer, which may be related to the US nuclear weapons tests conducted during the Cold War. Additionally, many who do have health insurance through their employers cannot afford the co-pays for hospital visits and medication, leaving the health insurance largely unused.

All of this, as I outline throughout this thesis, is a structural violence and global health problem resulting from the continuing colonial relationship between the United States and the Marshall Islands.

Significance of Findings

I omitted much of the data from my findings from this thesis, since they were irrelevant to my central argument. However, I found the auxiliary information to be important in contextualizing my data analysis. The data presented in this paper is significant for many reasons. Chief among them is the formal presentation of some of the COFA migrants' more pressing health needs. Also important (and noted below) is the proposal for relatively simple legislation that would go far to address the needs of Marshallese COFA migrants.

Many other data I found, such as domestic and international patterns of migration or social dimensions of the Springdale Marshallese, are new to academic literature. These findings push past purely economic perspectives of Pacific immigrants, providing valuable insight into actual reasons for migration, as well as ways to ease transition into the US and to address miscellaneous problems facing the Springdale Marshallese. These new findings brought up a problem, however: there are many questions but few data on the subject of Marshallese in the US.

Questions Raised by this Research

From the very beginning of my research, it was clear that there is a need for hard data and academic literature on Marshallese COFA migrants in the United States. Even the most basic data sets—such as US census data—is generally accepted to be inaccurate,

when it comes to listing Marshallese. Legislation, academia, and civil society could all benefit from more data—and the insights it brings—in areas such as population, education, employment, household size, and even Marshallese opinions on various issues.

Also worth considering is a comparative study of the Marshallese population of Springdale against other large Marshallese populations in the US. For example, my interviews and research conducted in Arkansas and Hawaii reveal that public perception is that the Springdale Marshallese face far less severe racism, legal battles, and other immigrant barriers than the Hawaii Marshallese. Such a study could reveal the legislation, social climates, or other circumstances that lead some Marshallese to choose one population over another, or what structures, laws, and systems, make living conditions better in another state. My findings that Marshallese, when older, often leave Arkansas to live in Washington or California in order to get Medicaid and Medicare coverage are a precursor to such a study—in this case, a significant pattern of domestic migration is caused by a single difference in legislation while also revealing the Marshallese need for and valuation of publicly-funded healthcare.

How this Research Contributes to the Broader Field of Immigration Studies

My research on the relationship between the Marshall Islands and the United States is very similar to the relationships between the US and Palau and between the US and the Federated States of Micronesia. Since each of these relationships centers around a Compact of Free Association, my research could prove useful as a parallel to research on Palauans or Micronesians in the US.

The US continues to maintain colonial relationships with other states as well. My thesis could prove useful in examining Guam or Puerto Rico, for example. Even if my data is dissimilar, my literature review could prove helpful, as it is more widely applicable, although I focused it in a particular way.

It is also common for migration studies to examine current or past colonial relationships. Since my argument centers around this, I add to the larger set of literature on this topic. Because my topic is seldom covered, it presents new, unique, and potentially beneficial data or theory for analysis and criticism within the field of migration studies. This is essential in furthering any subject or field of study.

Wider Implications for Other Immigrant Groups

As I explain below, a congressional bill has been drafted that follows my recommendations. This was unintentional; I discovered the bill—H.R. 912—after writing my conclusion and recommendations. Since my research comes to that conclusion organically, it is in honest and direct support of it. It provides a concentrated case study that backs up the bill. If H.R. 912 were to pass, it would reinstate Medicaid and Medicare access for COFA migrants from all three COFA nations—not just the Marshall Islands—potentially benefiting thousands who live in the US.

My discussion of law and policy and its structural violence over immigrant groups is relevant to the discussion of other immigrant groups in the US. Indeed, my own research benefitted from this very discussion. I used Seth Holmes' texts on Mexican immigrants and the structural violence facing them and affecting their health in the US,

for example. My findings provide yet another text to add to this literature, while also addressing a less-studied aspect of it.

Recommendations

Certain changes can be made to address short-term structural problems facing Marshallese COFA migrants in Springdale. At the state level, Arkansas should petition to add COFA migrants to Medicaid expansion, relieving them of a major health and financial burden. The state should also introduce a Marshallese-language driver license test, a simple maneuver which would remove a major health and legal barrier affecting multiple facets of life.

Health officials should take care to understand the unique health patterns and needs of Marshallese in Springdale. An understanding of the structural and contextual factors affecting Marshallese health would also benefit treatment and health improvement. This requires intentional study, years of close community work, or increased academic and health literature on the topic. Further studies could gather and distribute much-needed data and figures on Marshallese population and health. Research can also reveal the major contexts for health, and thus methods for addressing them.

At the federal level, government social services eligibility should be re-enacted for COFA migrants, who are poor in health and in pocket due in large part to US militarization in the RMI, a structural violence stemming from years of colonial relations. In addition, this right was once promised to COFA migrants but was removed before the first COFA expired.

After finishing a complete draft of this thesis, I discovered that a bill outlining exactly this—reinstatement of social services eligibility for COFA migrants—has been proposed and drafted. Congressional bill H.R. 912: Restoring Medicaid for Compact of Free Association Migrants Act of 2013 was written and introduced by Congresswoman Colleen Hanabusa, who represents Hawaii. It has been assigned to a congressional committee in February 2013 and remains in consideration. Although it was inspiring to find a bill that matched exactly what I call for at the conclusion of my thesis, it is also disheartening: the US federal government’s bill tracker website, govtrack.us, gives it a 1% chance of being enacted (GovTrack.us 2013, n. pag.).

Looking to the Future

As I explored at the end of chapter 3, the Springdale Marshallese’ greatest hope is in its younger generation, in those born in the US who will have a vote when they turn 18. As they become adult US citizens, they will have a greater political voice. The current Compact of Free Association between the RMI and the US expires in 2024. There are no statements or laws concerning what the legal status of Marshallese COFA migrants would become if the Compact dissolved. At this point, however, it is likely the Compact will be renewed: the RMI does not have a strong enough economy to run itself, and the US will likely desire to keep its valuable Reagan Missile Test site on Kwajalein, as well as its military dominance over the Pacific.

The rate of migration from the Marshall Islands to the United States is increasing, and the travel privileges granted by the Compact may be utilized even further in the future in light of climate change, especially if the Compact is renewed. Carmen

mentioned the effects of climate change, pointing out the differences she saw after being away from the Marshall Islands for a few years. “If you’re out of the country for a while, stay away for so many years and then go back, you see how the water is eating up our land, our island. The shore keeps coming in.”⁸⁷ Climate change isn’t driving migration to the States, but it soon will be. The RMI Minister of Foreign Affairs Tony DeBrum pointed out that on atolls and islands as small and low-lying as those in the Marshalls, higher tides affect everything. ““As the tide comes in a lot higher than it used to, it begins to affect life as we know it. Not only as to where you can live or have a family, but also where you can grow your food, where you draw your water, and where you bury your dead”” (Raphael 2014, n. pag.). The Marshallese also have a strong connection to their land, meaning that when it is affected, so are their spiritual links to it and their ideas of home (Walsh 2003).

Carmen, as a government official, looks at the Marshallese through a long-term, global perspective. She is sure that life in the Marshall Islands will be even more difficult soon, and she has faith that the Compact will be the solution. “Long term ... I mean, other countries have a plan for evacuation because of climate change. So they’ve worked with—negotiated with—other countries. But for us, I think because of the Compact, we really cannot. It’s already here. We have a way to get out of the country. But you never know when the biggest tsunami will come.”⁸⁸ She laughed after saying this, but out of unease. She was, after all, telling me about the literal destruction of her country, a place

⁸⁷ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

⁸⁸ Consul General Carmen Chong-Gum, interview with author. September 9, 2014. Transcript.

she still considers home. Her reference to the Compact showed her relief that, although droughts grow longer and the King Tides cover more land each year, the Marshallese have a legal path to safety.

I predict that migratory flows from the Marshall Islands to Springdale, and to the United States as a whole, will only grow stronger as more social capital is accumulated in Springdale and other population centers and as push factors in the RMI make emigration more appealing. I also expect the steady rise in sea levels and other climate change-related weather events—such as fiercer hurricanes, elongated droughts, and higher tides—will turn the steady migration into a mass flight. The Marshallese will become one of the first and biggest groups of climate refugees we've ever seen, as their vulnerable and low-lying atolls are affected early on. Of course, the RMI won't be the only country affected, but they could become the canary that marks the point at which we're powerless to stop the anthropogenic effects on Earth's climate. The contingency plan, by default, is just what Carmen said. It is the Compact of Free Association, and literal and figurative flight to the US.

Once again the Marshallese' land, already difficult to inhabit, is threatened. This time, it is not by nuclear weapons or skirmishes between US and Japanese forces, but by the collective efforts of the developed and developing world. Once again, they face displacement with no possibility of return. Now, however, they will not be barred from just four irradiated atolls, but potentially from their entire submerged state.

When this happens, the Compact, which currently keeps many Marshallese in the US from obtaining healthcare, may be a path to safety for COFA migrants. This would mean that the US, which maintains a long and contentious history of nuclear testing, militarization, and displacement with the RMI, could become a final refuge for the Marshallese.

Bibliography

- Abercrombie, Neil and Patricia McManaman. 2014. "COFA Residents and Health Care Assistance in Hawaii." Hawaii Department of Human Services. <http://humanservices.hawaii.gov/wp-content/uploads/2014/11/COFA-Background-Memo.pdf>
- Accorsi, Sandro, Gebre Ab Barnabas, Pasquale Farese, Valeska Padovese, Margherita Terranova, Vincenzo Racalbutto, and Aldo Morrone. 2009. "Skin Disorders and Disease Profile of Poverty: Analysis of Medical Records in Tigray, Northern Ethiopia, 2005–2007." *Transactions Of The Royal Society Of Tropical Medicine And Hygiene* 103, 469-475.
- Agence France-Presse*. 2010. "Pacific Slum District a 'Health Risk' to Residents: US Army." July 23, 2010.
- Amin, Samir. 1976. *Unequal Development: An Essay on the Social Formations of Peripheral Capitalism*; translated by Brian Pearce. New York: Monthly Review Press, 1976.
- Amnesty International. 2011. "Egypt: Stop Forced Eviction and Consult Slum-dwellers to Resolve Housing Crisis." News and Updates: Reports, 23 August 2011. <http://www.amnesty.org/en/news-and-updates/report/egypt-stop-forced-evictions-and-consult-slum-dwellers-resolve-housing-crisis>.
- Ariely, Dan. 2009. "The End of Rational Economics." *Harvard Business Review* 87, no. 7/8: 78-84.
- Asian and Pacific Islander American Health Forum. 2014. "Key Facts on Medicaid Restoration for COFA Migrants." <http://www.apiahf.org/programs/nhpi-affairs/community-capacity-building/medicaid-restoration-compact-free-association-mi-0> (accessed November 16, 2014).
- Asian and Pacific Islander American Health Forum. 2014. "Medicaid Restoration for Compact of Free Association Migrants." <http://www.apiahf.org/policy-and-advocacy/policy-priorities/health-care-access/medicaid-restoration-compact-free-associati> (accessed November 21, 2014).
- Aurecon, Ltd. 2008. "Informal Settlement Vulnerability Index: Final Report." Prepared for Strategic Support and Research, Dept. of Local Government and Housing, and Provincial Government of the Western Cape.
- Azios, Tony. 2010. "Uncle Sam wants Micronesians for US Military." *The Christian Science Monitor*, May 5, 2010.

- Battams, Samantha, and Stephen Matlin. 2013. "Global Health Diplomacy Briefing: Discussing a Definition of Global Health." The Graduate Institute, Geneva—Global Health Program.
- BBC Monitoring International Reports*. 2006. "Marshall Islands Government Injects Money into Ebeye." July 31, 2006.
- Beaglehole, Robert and Ruth Bonita. 2010. "What is Global Health?" *Global Health Action*. Published online April 6, 2010; 3: 10.3402/gha.v3i0.5142.
- Beatty, Mark E., *et al.* 2004. "An Outbreak of *Vibrio cholerae* O1 Infections on Ebeye Island, Republic of the Marshall Islands, Associated with Use of an Adequately Chlorinated Water Source." *Clinical Infectious Diseases* 38, no. 1 (January 2004): 1-9.
- Bertram, I. G., and R. F. Watters. 1985. "The MIRAB Economy in South Pacific Microstates." *Pacific Viewpoint* 26, no. 2: 497-519.
- Bertram, G. 1999. "The MIRAB model twelve years on." *Contemporary Pacific* 11, no. 1: 105-138.
- Bertram, Geoff. 2006. "Introduction: The MIRAB model in the twenty-first century." *Asia Pacific Viewpoint* 47, no. 1: 1-13.
- Bourdieu, Pierre. 1986. "The Forms of Capital." *Handbook of Theory and Research for the Sociology of Education*, ed. J. Richardson. New York: Greenwood.
- Bowden, Bill. 2013. "Legal status hindering Marshallese, study says." *Arkansas Democrat-Gazette: Northwest Edition (AR)*, January 09. 7.
- Bozorgmehr, Kayvan. 2010. "Rethinking the 'global' in global health: a dialectic approach." *Globalization & Health* 6, 19-37. Academic Search Complete, EBSCOhost (accessed October 3, 2014).
- Brown, Steve. 2013. "Archaeology of Brutal Encounter: Heritage and Bomb Testing on Bikini Atoll, Republic of the Marshall Islands." *Archaeology In Oceania* 48, no. 1: 26-39.
- Brown, T.M., M. Cueto, and E. Fee. 2006. "Public Health Then and Now. The World Health Organization and the Transition from 'International' to 'Global Public Health.'" *American Journal of Public Health* 96, no. 1:62-72.

- Bunyanavich, Supinda, and Ruth B. Walkup. 2001. "US Public Health Leaders Shift Toward a New Paradigm of Global Health." *American Journal of Public Health* 91, no. 10: 1556-1558.
- Cairns, Jr., John. 2008. "Putting Bioterrorism in Perspective." *Bioterrorism and Biological Warfare*. Jaipur: Pointer Publishers.
- Campbell, Ruth M., Maja Pleic, and Hillary Connolly. 2012. "The Importance of a Common Global Health Definition: How Canada's Definition Influences its Strategic Direction in Global Health." *Journal of Global Health* 2, no. 1:1.
- Carucci, Laurence Marshall. 2012. "You'll Always be Family: Formulating Marshallese Identities in Kona, Hawai'i." *Pacific Studies*, Vol. 35, Nos. 1/2. April/Aug. 2012.
- Césaire, Aimé, and Robin D. G. Kelley. 2000. *Discourse on Colonialism*. New York: Monthly Review Press, 2000.
- Choi, Jin Young. 2008. "Seeking Health Care: Marshallese Migrants in Hawai'i." *Ethnicity & Health*, Vol. 13, No. 1, January 2008, 73-92.
- Christie, D. J., R. V. Wagner, and D. A. Winter (Eds.). 2001. *Peace, Conflict, and Violence: Peace Psychology for the 21st Century*. Englewood Cliffs, New Jersey: Prentice-Hall.
- CIA World Factbook: Marshall Islands. "The World Factbook." Central Intelligence Agency, Library. (Online Resource Accessed Nov. 23, 2014).
- Coppock, Mike. 2014. "Enid Schools Work with a Different Minority Group." *The Washington Times*, Sun. Oct. 5, 2014.
- Cronkite, E. P., V. P. Bond, L. F. Browning, W. H. Chapman, S. H. Cohn, R. A. Conard, C. L. Dunham, R. S. Farr, W. S. Hall, R. Sharp, N. R. Shulman. 1954. "Study of Response of Human Beings Accidentally Exposed to Significant Fallout Radiation." Naval Medical Research Institute and U. S. Naval Radiological Defense Laboratory.
- Davis, Mike. 2007. *Planet of Shums*. New York: Verso, 2007.
- Department of Labor. 2014. "Cargill Agrees to Pay More than \$2.2M to Settle Charges of Hiring Discrimination Brought by US Labor Department." United States Department of Labor. January 22, 2014.

- Etzioni, Amitai. 2014. "Treating Rationality as a Continuous Variable." *Society* 51, no. 4: 393-400.
- Fanon, Frantz, Richard Philcox, Jean-Paul Sartre, and Homi K. Bhabha. 2004. *The Wretched of the Earth*; translated from the French by Richard Philcox; with commentary by Jean-Paul Sartre and Homi K. Bhabha. n.p.: New York : Grove Press, 2004., 2004.
- Farmer, Paul. 1999. *Infections and Inequalities: The Modern Plagues*. Berkeley: University of California Press, 1999.
- Farmer, Paul. 2003. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*; foreword by Amartya Sen. Berkeley: University of California Press, 2003.
- Farmer, Paul. 2006. "Never Again? Reflections on Human Values and Human Rights." The Tanner Lectures on Human Values, Vol. 25. Salt lake City: University of Utah Press, 2006: pp. 137-188.
- Fazzino II, David V. 2010. "Whose Food Security? Confronting Expanding Commodity Production and the Obesity and Diabetes Epidemics." *Drake Journal of Agricultural Law* 15, no. 3: 393-417.
- Fitzpatrick, Kevin M. 2011. "Northwest Arkansas: Point-in-Time Homeless Census." Community and Family Institute. Department of Sociology, University of Arkansas.
- Fraenkel, Jon. 2006. "Beyond MIRAB: Do aid and remittances crowd out export growth in Pacific microeconomies?." *Asia Pacific Viewpoint* 47, no. 1: 15-30.
- Friberg, Emil, Kendall Schaefer, and Leslie Holen. 2006. "US Economic Assistance to Two Micronesian Nations: Aid Impact, Dependency and Migration." *Asia Pacific Viewpoint* 47, no. 1: 123-133.
- Fried, Linda P., Margaret E. Bentley, Pierre Buekens, Donald S. Burke, Julio J. Frenk, Michael J. Klag, and Harrison C. Spencer. 2010. "Global Health is Public Health." *The Lancet* 375 (9714): 535-7.
- Friedman, Mark. 2014. "UAMS Gets \$2.1 Million For Marshallese Health Study." *Arkansas Business*, August 25, 2014.
- Galtung, Johan. 1969. "Violence, Peace, and Peace Research." *Journal of Peace Research* 6, no. 3: 167.

- Galtung, Johan. 1990. "Cultural Violence." *Journal of Peace Research* 27, no. 3: 291-305.
- Ganz, Michael L., Neil Wintfeld, Li Qian, Veronica Alas, Jakob Langer, and Mette Hammer. 2014. "The Association of Body Mass Index with the Risk of Type 2 Diabetes: A Case—Control Study Nested in an Electronic Health Records System in the United States." *Diabetology & Metabolic Syndrome* 6, no. 1: 1-17.
- Gilligan, James. 1997. *Violence: Reflections on a National Epidemic*. New York: Vintage Books, 1997.
- Gorenflo, L. J., and Michael J. Levin. 1989. "The Demographic Evolution Of Ebeye." *Pacific Studies* 12, no. 3 (July 1989): 91-128.
- GovTrack.us. 2013. 'Restoring Medicaid For Compact Of Free Association Migrants Act Of 2013 (H.R. 912)'. <https://www.govtrack.us/congress/bills/113/hr912> (accessed Dec. 26, 2014).
- Gramsci, Antonio. 1971. *Selections from the Prison Notebooks of Antonio Gramsci*, edited and translated by Quintin Hoare and Geoffrey Nowell Smith. New York: International Publishers.
- Grosfoguel, Ramón. 2003. *Colonial Subjects: Puerto Ricans in a Global Perspective*. Berkeley: University of California Press, 2003.
- Guariguata, Leonor, Tim Nolan, Jessica Beagley, Ute Linnenkamp, and Oliver Jacqmain, eds. 2013. *IDF Diabetes Atlas*, 6th edition. International Diabetes Federation.
- Haberkorn, Gerald. 2007. "Pacific Islands' Population and Development: Facts, Fictions and Follies." *New Zealand Population Review* 33/34, (May 2007): 95-127.
- Hanabusa, Colleen, Madaleine Bordallo, Eni Faleomavaega, Gregorio Sablan, Tulsi Gabbard. 2013. "Restoring Medicaid for Compact of Free Association Migrants Act of 2013." H.R. 912, 113th Congress, 1st Session.
- Hansen, Helena, Seth Holmes, and Danielle Lindemann. 2013. "Ethnography of Health for Social Change: Impact on Public Perception and Policy." *Social Science & Medicine*, Volume 99, December 2013, pp: 116-118.
- Harvey, David. 1989. *The Condition of Postmodernity: An Enquiry into the Origins of Cultural Change*. Oxford; Cambridge: Blackwell, 1989.

- Hezel, Francis X. 1995. *Strangers in Their Own Land: A Century of Colonial Rule in the Caroline and Marshall Islands*. Honolulu: University of Hawaii Press, 1995.
- Hezel, Francis X. 1983. *The First Taint of Civilization: A History of the Caroline and Marshall Islands in Pre-Colonial Days, 1521-1885*. Honolulu: University of Hawaii Press, 1983.
- Hirata, Alexander. 2014. "Structural Violence as a Global Health Problem: Ebeye Case Study." Global Health and Food Security assignment, University of San Francisco, 2014.
- Holmes, Seth M. 2013. "'Is it Worth Risking Your Life?': Ethnography, Risk and Death on the U.S.-Mexico Border." *Social Science & Medicine*, Volume 99, December 2013, pp: 153-161.
- Holmes, Seth M. 2013. "The Clinical Gaze in the Practice of Migrant Health: Mexican Migrants in the United States." *Social Science & Medicine*, Volume 99, December 2013, pp: 873-881.
- Hyde, Terri B, *et al.* 2006. "Measles Outbreak in the Republic of the Marshall Islands, 2003." *International Journal Of Epidemiology* 35, no. 2 (April 2006): 299.
- Hyman, Mark. 2010. "The Link Between Poverty, Obesity and Diabetes." *Huffington Post*. September 18, 2010.
- Ichihō, Henry M., Johannes Seremai, Richard Trinidad, Irene Paul, Justina Langidrik, and Nia Aitaoto. 2013. "An Assessment of Non-Communicable Diseases, Diabetes, and Related Risk Factors in the Republic of the Marshall Islands, Kwajelein Atoll, Ebeye Island: A Systems Perspective." *Hawaii Journal Of Medicine & Public Health* 72, 77.
- Jimeno S., Rafael A. 2013. *A Profile of the Marshallese Community in Arkansas, Volume 3*. Little Rock, AR, and Fayetteville, AR: Winthrop Rockefeller Foundation and University of Arkansas.
- Kellams, Laura. 2013. "Marshallese Families and the Affordable Care Act: A Fact Sheet." Arkansas Advocates for Children and Families.
- Kickbusch, Ilona. 2002. "Global Health—A Definition." <http://www.ilonakickbusch.com/kickbusch-wAssets/docs/global-health.pdf> (accessed October 8, 2014).

- Kickbusch, I. 2006. "The need for a European strategy on global health." *Scandinavian Journal Of Public Health* 34, no. 6: 561-565. CINAHL Complete, EBSCOhost (accessed October 4, 2014).
- Kickbusch, Ilona, and Martina Marianna Cassar Szabo. 2014. "A new governance space for health." *Global Health Action* 7, 1-7. Academic Search Complete, EBSCOhost (accessed October 3, 2014).
- Kiste, Robert C. 1974. *The Bikinians: A Study in Forced Migration*. Menlo Park, California: Cummings Publishing Company, 1974.
- Koplan, J.P., T.C. Bond, M.H. Merson, K.S. Reddy, M.H. Rodriguez, N.K. Sewankambo, and J.N. Wasserheit. 2009. "Towards a Common Definition of Global Health." *The Lancet* 373, no. 9679: 1993-1995.
- Lee, Kelley, and Adam Kamradt-Scott. 2014. "The Multiple Meanings of Global Health Governance: A Call for Conceptual Clarity." *Globalization & Health* 10, no. 1: 1-21.
- Levine, James A. 2011. "Poverty and Obesity in the U.S." *Diabetes*, 60 (11): 2667-2668. October 17, 2011.
- Lopez, C. Todd. 2011. "Good Neighbor Policy." *Soldiers* 66, no. 3 (March 2011): 40-42.
- Marsters, E., N. Lewis, and W. Friesen. 2006. "Pacific flows: The fluidity of remittances in the Cook Islands." *Asia Pacific Viewpoint* 47, no. 1: 31-44.
- Massey, Douglas S., Joaquin Arango, Graeme Hugo, Ali Kouaouci, Adela Pellegrino, J. Edwards Taylor. 1993. "Theories of International Migration: A Review and Appraisal." *Population and Development Review*, Vol. 19, No. 3 (Sep., 1993), pp. 431-466.
- Matheson, Scott. 2011. "The Informal Housing Crisis in Cape Town and South Africa." Department of Geography. Ohio State University.
- Mayer-Foulkes, David A., and Claudia Pescetto-Villouta. 2012. "Economic Development and Non-Communicable Chronic Diseases." *Global Economy Journal* 12, no. 4 (December 2012): -1.
- McElroy, Jerome L, and Courtney E Parry. 2010. "The characteristics of small island tourist economies." *Tourism & Hospitality Research* 10, no. 4: 315-328.

- McElroy, Jerome L., and Perri E. Hamma. 2010. "SITEs revisited: Socioeconomic and demographic contours of small island tourist economies." *Asia Pacific Viewpoint* 51, no. 1: 36-46.
- Merriam-Webster's Collegiate Dictionary*. 2009. "immigrant." *Merriam-Webster's Collegiate Dictionary*, 11th ed.
- Missoni, Eduardo, Fabrizio Tediosi, Guglielmo Pacileo, and Lara Gautier. 2014. "Italy's contribution to global health: the need for a paradigm shift." *Globalization & Health* 10, no. 1: 1-23. Academic Search Complete, EBSCOhost (accessed October 3, 2014).
- Murphy, Raymond E. 1950. "The Economic Geography of a Micronesian Atoll." *Annals of the Association of American Geographers* 40.1 (1950): 58-83. SocINDEX with Full Text. Web. 3 March 2014.
- "New York (City) QuickFacts from the US Census Bureau." 2013. *State and Country Quick Facts: New York (City), New York*. United States of America, 27 June 2013. Web. 03 Nov. 2013.
- Niedenthal, Jack. 2001. *For the Good of Mankind: A History of the People of Bikini and their Islands*, 2nd Edition. Majuro, Marshall Islands: Bravo Publishing, 2001.
- Northwest Arkansas Business Journal Editors. 2014. "Cargill Pays More Than \$2.2M To Settle Discrimination Suit." *Northwest Arkansas Business Journal*. January 22, 2014.
- ObamaCare Facts. 2014. "Federal Poverty Level 2014-2015." <http://obamacarefacts.com/federal-poverty-level/> (accessed Nov. 29, 2014).
- Oberst, Ashly, and Jerome L. McElroy. 2007. "Contrasting Socio-Economic and Demographic Profiles of Two, Small Island, Economic Species: MIRAB versus PROFIT/SITE." *Island Studies Journal* no. 2: 163.
- Quijano, Anibal. 2000. "Coloniality of Power, Eurocentrism, and Latin America." *Nepantla: Views From South* no. 3: 533.
- Radio Australia*. 2006. "Marshall Islands' President Asked to Declare Emergency on Ebeye." July 20, 2006.
- Raphael, T.J., ed. 2014. "Climate Change Threatens to Destroy Marshall Islands." *The Takeaway*. Monday, September 22, 2014.

- Republic of the Marshall Islands. Economic Policy, Planning, and Statistics Office. 2012. *The RMI 2011 Census of Population and Housing: Summary and Highlights Only*. Office of the President.
- Reddy, R, et al. 2009. "Marshallese Diabetic Health Improvement Pilot Project in Ebeye." *Californian Journal Of Health Promotion* 7, (December 2, 2009): 1-6.
- Rowson, Mike, Chris Willott, Rob Hughes, Arti Maini, Sophie Martin, J. Jaime Miranda, Vicki Pollit, Abi Smith, Rae Wake, and John S. Yudkin. 2012. "Conceptualising global health: theoretical issues and their relevance for teaching." *Globalization & Health* 8, no. 1: 36-43. Academic Search Complete, EBSCOhost (accessed October 3, 2014).
- Said, Edward. 1979. *Orientalism*. New York: Vintage Books (a Division of Random House), 1979.
- Scholte, Jan Aart. 2002. "What is Globalization? The Definitional Issue—Again." The University of Warwick Centre for the Study of Globalisation and Regionalisation. Coventry: University of Warwick, December 2002.
- Sen, Amartya. 2008. "Why and How is Health a Human Right?" *The Lancet* 372, no. 9655: 2010.
- Shek, Dina, and Seiji Yamada. 2011. "Health care for Micronesians and constitutional rights." *Hawaii Medical Journal* 70, no. 11 Suppl 2: 4-8.
- Spenneman, Dirk, ed. 2002. "Pilot Survey of Marshallese Living in Arkansas, Guam, Hawaii, the CNMI and in the Marshalls: Preliminary Results." April 01, 2002. Embassy of the Republic of the Marshall Islands.
- Spivak, Gayatri Chakravorty. 1988. "Can the Subaltern Speak?" *Marxism and the Interpretation of Culture*. Eds. Cary Nelson and Lawrence Grossberg. Urbana, IL: University of Illinois Press, 1988: 271-313.
- TendersInfo News (Mumbai, India)*. 2013. "Australia: Australian Emergency Drought Assistance Increased to the Marshall Islands." June 13, 2013.
- U.S. Government Accounting Office. 2003. "Compact of Free Association: An Assessment of the Amended Compacts and Related Agreements: GAO-03-890T." GAO Reports.

- U.S. Government Accounting Office. 2007. "Compacts of Free Association: Micronesia's and the Marshall Islands' Use of Sector Grants: GAO-07-514R." GAO Reports.
- U.S. Government Printing Office. 1996 104th Congress Public Law 193. [http://http://www.gpo.gov/fdsys/pkg/PLAW-104publ193/html/PLAW-104publ193.htm](http://www.gpo.gov/fdsys/pkg/PLAW-104publ193/html/PLAW-104publ193.htm) (accessed November 16, 2014).
- Wallerstein, Immanuel Maurice. 1974 *The Modern World-system*. New York: Academic Press, 1974
- Wallerstein, Immanuel Maurice. 1979. *The Capitalist World-economy: Essays by Immanuel Wallerstein*. Cambridge; New York: Cambridge University Press, 1979.
- Walsh, Julianne M. 2003. "Imagining the Marshalls: Chiefs, Traditions, and the State on the Fringes of the U.S. Empire." PhD diss., University of Hawaii, 2003.
- Westcott, Lucy. 2014. "Marshall Islands Nuclear Lawsuit Reopens Old Wounds." *Newsweek*, August 1, 2014.
- Williams, DP, and A Hampton. 2005. "Barriers to Health Services Perceived by Marshallese Immigrants." *Journal of Immigrant Health* 7, no. 4: 317-326.
- Willman, David. 2014. "\$40-Billion Missile Defense System Proves Unreliable." *LA Times*, June 15, 2014.
- Woodall, Patricia, David Scollard, and Latha Rajan. 2011. "Hansen Disease among Micronesian and Marshallese Persons Living in the United States." *Emerging Infectious Diseases* 17, no. 7: 1202-1208.
- Woodard, Colin. 2000. "Time to Re-up at Kwajalein." *Bulletin Of The Atomic Scientists* 56, no. 1 (January 2000): 19.
- Yach, Derek, and Douglas Bettcher. 1998. "The Globalization of Public Health, I: Threats and Opportunities," *American Journal of Public Health* 88, no. 5: 735-738 and "The Globalization of Public Health, II: The Convergence of Self-interest and Altruism." *American Journal of Public Health* 88, no. 5: 738-741.
- Youngblood Coleman, Denise. 2012. "Environmental Issues." *Marshall Islands Country Review*. July 2012.