Introduction

Northwest Arkansas (NWA) is a major immigration destination for the Marshallese people housing one of the largest populations in the continental United States (US). This trend is becoming more evident within the healthcare systems of NWA, yet this is difficult to statistically illustrate with current census methodology. The 2010 US Census reported the Marshallese population under the title “Native Hawaiians and other Pacific Islanders” which showed a 251.5% increase in population in Arkansas. The Marshallese population for NWA is estimated at 6,000-10,000 (Arkansas, 2007). This group is composed primarily of immigrants, therefore this population’s health status is reflective of the current health status of the Republic of the Marshall Islands (RMI) (Williams, 2005).

The Republic of the Marshall Islands (RMI) is a small country consisting of 29 coral atolls with a total land area of 70 square miles with Exclusive Economic Zone covering 750,000 square miles (Kroon, 2004; Central, 2011). This total land area of 70 square miles is the home of approximately 67,182 individuals (Central, 2011). The health disparities present in the RMI include communicable and non-communicable diseases due to dense population and inadequate water supply, degenerative chronic diseases associated with lifestyle changes due to environmental damage from US weapons testing, and little preventative care due to limited healthcare facilities and ideology (Choi, 2008; Pollock, 2002; Williams, 2005). The health status of migrating Marshallese people is less than ideal, yet this can be exacerbated by barriers to the western medical model (Williams, 2005). These health disparities have been witnessed within NWA and will continue unless healthcare professionals and facilities become proactive in providing culturally competent healthcare services.

Scope of Issue

Within the Republic of the Marshall Islands, there are only two hospitals, limited community clinics, and very limited healthcare providers that travel to the exterior atolls to provide medical care for the entire population (Kroon, 2004; World, 2006). This limited service leaves little opportunity to receive effective preventative care. As a result hospitalization tends to be limited to those individuals with more dire health statuses. The US government’s involvement in healthcare has also increased the uncertainty of receiving unbiased care (Pollock, 2002). The Marshallese viewpoint of US health interventions involved intense examinations without explanations of findings or health status (Pollock, 2002). Individuals have been reassured that they are “healthy” despite major health complications, fetal defects, and high infant mortality (Pollock, 2002). These interactions are part of the Marshallese cultural memory and lead to distrust of the western medical model.

The limited medical services and American interaction within the RMI gives one insight to the population’s medical care expectations and concerns. When one has learned to function within a sparse medical model altering this schema to accommodate a new model is not instantaneous.

Advocacy Plan

Four major barriers to healthcare for Marshallese patients include: gender, language, finances, and trust (Pollock, 2002; Tanjasiri, 2007; Williams, 2005).

Gender: Within the Marshallese culture topics such as reproduction and fertility are not acceptable to be discussed between opposite genders. This may require a team approach to providing care e.g. having a specific gendered caregiver perform more intimate examinations/interviews.

Language: Language barriers that are experienced tend to be due to lack of comfort communicating in English, especially while discussing a distressing health condition. A survey distributed throughout limited English proficiency (LEP) Asian American and Pacific Islanders (AAPI) of California illustrated that 75% of respondents preferred speaking a language other than English with healthcare providers (Dang, 2010). Literature supports the use of interpreters to increase comfort level and therefore follow up of treatment (Dang, 2010; Williams, 2005).

Finances: Financial impact healthcare availability for almost all populations. The Marshallese client may not qualify for government funded programs therefore postponing care until establishing health insurance. This situation is compounded when one is required to take time off work in order to seek treatment due to office and treatment hours. This could be eased by the healthcare provider’s familiarity with information pamphlets and local support programs such as: “Living in Arkansas” provided by The Gaps in Services to Marshallese Task Force in Springdale, AR (Arkansas, 2007). In addition, mobile medical units providing follow up care and preventative education has been a very effective approach to improving health status within NWA populations, as illustrated by the health departments efforts to treat and educate to tuberculosis (Block, 2004; Tanjasiri, 2007).

Trust: Lastly, the amount of trust in the western medical model depends on previous interactions between family/community members and US representatives. Successful interaction between two cultures requires a certain amount of acculturation on each member involved. The acculturation process varies for each individual, thus healthcare providers need to establish a relationship of trust in order to effectively provide care.

Eliminating these barriers can increase preventative and follow up treatment while reducing cost through effective communication between Marshallese clients and healthcare professionals.