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# Effects of Cultural and Lived Experiences on Health Access of Chamorro People on Saipan

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2020

Abstract

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MHA, Saint Joseph's College, 2007

BGS, Indiana University, 2001

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services– Health Administration

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# Abstract

More than half of the population of the Commonwealth of the Northern Mariana Islands had not visited their primary care provider for a year in 2016. The Chamorro people are less willing to seek or access care than other ethnic groups. This qualitative study aimed to understand the Chamorro people’s access and utilization of Saipan's health care services to improve their access and, ultimately, their health. The theoretical frameworks included Penchansky and Thomas's theory of access to explore the Chamorro people of Saipan's lived experiences with availability, accessibility, accommodation, affordability, and acceptability of health care services, as well as Spector's cultural diversity in health and illness to explore the lived experiences of the Chamorro people of Saipan with the environmental control, biological variations, social organization, communication, space, and time orientation. A purposeful sample of 12 Chamorro adults over age 18 who live on Saipan were interviewed using phenomenological heuristic inquiry. Findings from 2-cycle coding indicated that many services were only accessible by going off-island, which has a significant impact on family and financial situations. This study can be considered preliminary research on how the Chamorro people on Saipan access and utilize health care services. One recommendation for further research is to conduct similar research on a more specific group within this population. The Chamorro people can benefit from this study when health service professionals and administrators ensure a more appropriate health delivery system for this population.

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APA 6

# Dedication

I want to dedicate this research to Almighty God for guiding me and giving me the graces and strength and for His love.

I also want to dedicate this to my beloved parents, Jose and Juliana Lizama. Although they are no longer here on this earth, they have been my role model in everything I do.

# Acknowledgments

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# Chapter 1: Introduction to the Study

The Chamorro people on Saipan in the Commonwealth of the Northern Mariana Islands (CNMI) have high rates of diabetes and treated diabetic end-stage renal disease cases (Abidi, Negrete, Zahid, Bennett, & Nelson, 2005). Chamorro women also have a high mortality rate from breast cancer (Guerrero et al., 2017). Although many factors contribute to these rates for Pacific Islanders overall (Tervonen, Foliaki, Bray, & Roder, 2017), health care access is one factor that exists (Tsai, Whealin, & Pietrzak, 2014). According to Rosario (2010), the Chamorro people, one of the two indigenous populations on the island of Saipan, do not access preventive care compared to other ethnicities on the island. The Chamorro people are also known to have health perceptions and concerns that have links to their culture (Torsch & Ma, 2000).

The purpose of this study was to understand the Chamorro people's experiences and behaviors towards health services and health and how these experiences and behaviors affected their access and utilization of health services. This study's findings supported the Chamorro people of Saipan's view on the current health system and their health and their means of coping with it. I conducted this research to address a gap by understanding the Chamorro people's health services access and utilization because such information did not exist elsewhere for this population. The study's social change implications should help health service professionals and administrators ensure a more appropriate health delivery system for this population and help them improve their health access and utilization and, ultimately, their health.

This chapter describes health access problems, the research gap for this population, its purpose, and the research questions. I identify the theories that guided this study and explain how they relate to the research and the research questions. I also introduce the scope of the study, the assumptions, limitations, and delimitations. Lastly, I provide the social implications of this research and a transition to the literature review and Chapter 2.

## Background

Access to health care and a primary health care provider affects the health of vulnerable populations (Gilliland, Shah, Clark, Sibbald, & Seabrook, 2019), such as the Chamorro people. Barriers to access influence the way individuals and populations access health care (Penchansky & Thomas, 1981; Spector, 2002). As in other populations, some individuals' access to health care is affected by their finance and insurance coverage (Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004). Another barrier is the past negative experience of the population, which contributes to the overall perception of health care and the health systems (Blankenau, Comer, Nitzke, & Stabler, 2010; George, Daniels, & Fioratou, 2018). The Chamorro people on Saipan has a history of overcoming natural disasters and other challenges (Pietrusewsky, Douglas, Swift, Harper, & Fleming, 2014). They have also been influenced by how they respond to health care by their colonial health care experience (Stoil, Murthy, & Kuramoto, 2006). With strong Catholic faith, the Chamorro people believe in fatalism, and according to Shahid, Finn, Bessarab, and Thompson (2009), fatalism affects decisions around accessing health care. These experiences and beliefs have built barriers to health care access for the Chamorro people.

The knowledge gap was finding what specific barriers prevented the Chamorro people on Saipan from accessing health care services. The Chamorro people are one of two indigenous communities on the island, and they are one of the least studied ones. This study was needed to improve the health access of the Chamorro people. By conducting qualitative research, I was able to get details of what prevents the Chamorro people from accessing health care. I determined which of the dimensions of access to health services described by Penchansky and Thomas (1981) applied to this population. Health administrators and policymakers could utilize this study to develop policies that will help remove the barriers and aid the Chamorro people on Saipan in accessing much-needed health services. When the government changes people's health experiences and perceptions, it can improve health care access and utilization (Nelson & Wilson, 2018).

## Problem Statement

The leading causes of death on Saipan are circulatory diseases, cancers, or metabolic diseases (Encinares, 2017). The Chamorro people in Saipan have the highest incidence rates of these diseases (Ichiho, Robles, & Aitaotao, 2013). These rates are of considerable concern as the Chamorro people represent only 21% of the entire population of the U.S. territory (U.S. Census Bureau, 2010). In a survey conducted by the Commonwealth of the Northern Mariana Islands (2016), 64.3% of the population were found not to have visited their primary care provider for over a year, and only 15.7% stated it was due to costs. Whereas the survey included all ethnicities, according to Rosario (2010), the Chamorro people were less willing to seek or access care than other ethnic groups. With the health outcomes showing some connection to health care access (Torsch & Ma, 2000), a phenomenological study was necessary.

Studies have been conducted with other populations on their experiences with health care access in the region they live in (Blankenau et al., 2010; Lee & Lee, 2018; Nelson & Wilson, 2018; Zuckerman et al., 2004). However, I could not find any studies specifically on access to health care with Saipan's Chamorro people. The Chamorro people in each of the Mariana Islands have different variables that affect their health, such as geography, environmental constraints, and social and cultural networking (Pietrusewsky et al., 2014). Therefore, the Chamorro people on Saipan do not share the same experience as that of Chamorro people on other islands in the Marianas or that of other islanders in the Pacific. My research was necessary to provide medical professionals and health administrators a better understanding of the access and utilization of the Chamorro people’s health care services on Saipan and to help improve their health status subsequently.

## Purpose of the Study

The purpose of this qualitative study was to understand how the experiences and culture of the Chamorro people of Saipan affect their access and utilization of health services. The qualitative research, using one-on-one interviews, focused on how the Chamorro people perceive and feel about their health and the health system. Understanding this phenomenon among the Chamorro people could help health administrators develop strategies to improve access to this specific population and help improve their health outcomes.

## Research Questions

Three research questions guided this study:

1. What are the lived experiences of the Chamorro people of Saipan with availability, accessibility, accommodation, affordability, and acceptability of health care services on the island?
2. What are the lived experiences of the Chamorro people of Saipan with the environmental control, biological variations, social organization, communication, space, and time orientation of the health care services in Saipan?
3. How do the cultural factors of environmental control, biological variations, social organization, communication, space, and time orientation impact the lived experiences of the Chamorro people of Saipan with availability, accessibility, accommodation, affordability, and acceptability of health care services on the island?

## Theoretical Framework

To understand how the Chamorro people access healthcare, I used the theory of access from Penchansky and Thomas (1981) and the theory of cultural diversity in health and illness from Spector (2002). Penchansky and Thomas's theory was that five dimensions affect access to care: availability, accessibility, accommodation, affordability, and acceptability. To achieve optimum access, these five dimensions of access must be obtained (Penchansky & Thomas, 1981). The second framework was Spector's theory that cultural diversity affects health care access. Spector's theory explained how the cultural diversities of environmental control, biological variations, social organization, communication, space, and time orientation affect health care access. For the Chamorro people, culture is one aspect that affects their health decisions to access care (Torsch & Ma, 2000), and using Spector's theory should help understand how.

## Nature of the Study

The nature of this research was qualitative, which aimed to identify patterns and processes and provide meaning and relevance to the study (Creswell, 2014). Qualitative research was appropriate to understand participants' experiences and how those experiences may have affected access and utilization of health services (Morse, 2004). The research design was a phenomenological heuristic inquiry. This approach looked at how a phenomenon of experiences and perceptions affect the access and utilization of services (Patton, 2015). This approach was appropriate to help identify any barriers to access and utilization of health care services and determine how experience and perceptions affect the access and utilization of health services. I conducted one-on-one interviews to explore how access and utilization occurs and understand the research participants' perception of their health experiences and how they access and utilize health services.

A researcher must have an evaluated and approved recruitment process and access from the institutional review board (IRB) before conducting their research. According to the U.S. Department of Health and Human Services (2020), this process is necessary to ensure no harm to the participants when conducting the research. Researchers must have the means to access the participants and their information without violating their privacy rights. Researchers must also obtain participants' informed consent detailing the study's reasons, the potential benefits for participation, the potential risks of participating, and the assurances of confidentiality (Patton, 2015).

According to Creswell (2014), the research sample size should be consistent with the researcher's method and where the point of saturation or consistency is reachable. I determined that I needed to conduct 12 one-on-one interviews to reach the saturation point and answer my research questions. To gather the 12 participants, I created and posted a request to become a participant through a social media platform.

## Definitions

*Aniti* – In the Chamorro language, this word describes the evil spirits (Hattori, 2004).

*Fiesta* – In the Mariana islands, it is a Catholic church or village celebration held in honor of their church's patron saint, where there is an abundance of food for all guests to enjoy (Leon Guerrero, Paulino, Novotny, & Murphy, 2008).

*Health disparity* – The increased burden of an adverse health outcome or health determinant within a specific subset of a population (Wheeler & Bryant, 2017).

*Historical trauma* – For the Chamorro people in the Mariana Islands, it is the cumulative or transgenerational nature of colonial trauma that can be from historical oppression, intracultural classism, intergenerational transmission of trauma, the stress of cultural adjustment, and colonial trauma (Pier, 1998).

*Medicaid program* – In the U.S. territories, the Medicaid program is different compared to that in the U.S. states. In the territories, the program has capped funding and statutory Federal Medical Assistance Percentage (Congressional Research Service, 2018).

*Medically indigent* – In the health care system of the United States, they are persons who do not have health insurance and who are not eligible for other health care such as Medicaid, Medicare, or private health insurance (Akin, Rucker, Hubbell, Cygan, & Waitzkin, 1989).

*Noncommunicable diseases* – This refers to medical conditions or diseases that are noninfectious and are the leading causes of death and disease burden worldwide (Oh, Kim, & Kim, 2016).

*Suruhanu* – In the Chamorro language, this word describes one who is called the medicine man or men (Torsch & Ma, 2000).

*Suruhana* – In the Chamorro language, this word describes one who is called the medicine woman or women (Torsch & Ma, 2000).

*Taotaomona* – In the Chamorro language, this word describes the people of the before that appear even after death (Hattori, 2004).

## Assumptions

Before this study, I noted several assumptions. First, I assumed that the participants would respond to their experiences truthfully and respond to the interview questions to the best of their knowledge. I also assumed that the participants want better access to health care services and want to achieve better health outcomes. Also, I assumed that there would be an interest in participating if they understood that this study could positively change their health and Saipan's health services. Lastly, I assumed those who refused to participate could not be convinced to participate even if they agreed with the study's purpose.

## Scope and Delimitations

This study's scope was the Chamorro people's experiences of health care access and their cultural and overall perspective of the health care system on the island of Saipan. This scope should help understand the Chamorro people's behaviors concerning health access and provide their perspectives that were never obtained, collected, or reported before.

I delimited the research to Chamorro people from the island of Saipan with specific dimensions. First, I included Chamorro adults older than 18 years because this age group from the target population could access health services without parental consent. I included Chamorro adults, whether or not they had a primary care provider. I also included Chamorro adults, whether or not they had an outpatient visit with a health care provider for at least the last 18 months. I did not exclude Chamorro individuals with chronic diseases. Even though the Chamorro people's health status was essential, the current study did not focus specifically on their health status factors.

I estimated the potential transferability of this research in health access studies affecting other Pacific island countries or territories with similar cultures and beliefs. I also figured the potential transferability in studies of health access concerning those Chamorro people from Saipan who are now living in other U.S. states or territories. The potential transferability should help researchers look for similarities or gaps in their studies.

## Limitations

When conducting one-on-one interviews, limitations are expected (Patton, 2015). In this qualitative study, I identified some limitations. One of those limitations was my own potential bias as a researcher. As the head of the hospital, I felt I needed to exclude individuals employed by the hospital. Even if advised that the study was independent of their employment for the hospital, hospital employees may be uncomfortable participating freely. They might fear that how they respond may lead to punitive employment outcomes. However, I included their immediate families if they showed that they volunteered to participate independently. As the researcher, I had to develop trust with all the participants, including the employees' family members. To ensure this, I provided complete disclosure of what I do, and I assured the participants that my role as a researcher was independent of this.

Another limitation was my own bias as a fellow Chamorro living on the island of Saipan. I had my personal experiences growing up on Saipan and my own experience accessing health services during the periods when the island's health system was evolving. I had to exercise neutrality and ensure awareness of this personal bias (Patton, 2015). It was essential to listen to the participants’ answers to provide their perspective and not my own. To ensure this, recording and documenting verbatim quotations from the participants were necessary (Patton, 2015).

## Significance

This study had potential contributions that could advance knowledge in health administration. It focused on a particular patient population, the Chamorro people on the island of Saipan, and how they might have an inconsistent and inadequate source of health services necessary to achieve positive health outcomes. When access to care is suboptimal, a patient has a limited source of support for the management of their health care via a primary care physician (Finney Rutten et al., 2015; Fullerton et al., 2018). The health administrator must then push initiatives that increase access and eliminate barriers to care (Kash, Spaulding, Johnson, & Gamm, 2014). To implement initiatives and advance policies to address the obstacles to health access for the Chamorro people on Saipan, I needed to acknowledge this population's uniqueness regarding their history and culture. By understanding their history and culture, we could understand the phenomenon of health access and how it affects this particular population.

The Chamorro people are not a populous group of people, and according to the U.S. Census Bureau (2010), they are a minority on the island of Saipan, despite them representing the indigenous group. They are also not a very healthy population, and according to Chiem et al. (2006), chronic diseases are more prevalent in Chamorro people than in other ethnic groups. This study could help policymakers and health care administrators provide additional support to this particular population to improve their health access and ultimately improve their health.

## Summary

Like other Pacific Islanders with a high prevalence of diabetes and other noncommunicable diseases (Hawley & McGarvey, 2015), the Chamorro people have poor health statuses (Pinhey, Heathcote, & Rarick, 1994). Previous studies had shown that numerous factors result in poor health outcomes, such as poor diet, lack of exercise, poor diabetes care practices, and lack of preventive care (Ichiho, Gillan & Aitaoto, 2013; Ogilvie, Patel, Narayan, & Mehta, 2018; Rosario, 2010). There was also the linkage between health access and health outcomes (Bacon, Riosmena, & Rogers, 2017). I chose to explore how the Chamorro people's experiences and culture on Saipan affect their access to care as I could not find research on this particular topic. Addressing this gap in research should help address the health issues of the Chamorro people.

In this chapter, I summarized health access issues for the Chamorro people and the study's need, including describing the gap in knowledge, the problem statement, and purpose. I also presented the theoretical frameworks I used, the nature of the research, the assumptions, the delimitations, the limitations, and the significance of this research. In Chapter 2, I will present a literature review on the Chamorro people’s health and the theoretical frameworks applied to other ethnic groups. In Chapter 3, I will describe the study's details, which included the actual method and design, data analysis, conclusions, and summary. In Chapter 4, I will provide the qualitative analysis results, and in Chapter 5, I will present the study's interpretation, which included the implications and recommendations for further research.

# Chapter 2: Literature Review

The Chamorro people, one of the indigenous populations on the island of Saipan, in the CNMI, are known to have very poor health. The literature review conducted for this study identified numerous gaps in research on this particular population. In this study, I addressed the Chamorro people's access and utilization of health services, offering information that did not exist for this population. This study made an original contribution to explaining the Chamorro people of Saipan's view on the current health system and how they access and utilize health services so that health service professionals and administrators can ensure a more fitting health delivery system for this population.

## Theoretical Foundation

### The Dimensions of Access

According to Rosario (2010), the Chamorro people are less willing to seek and access healthcare than other ethnic groups.  The Chamorro people on Saipan have a higher rate of illnesses than other ethnicities (Ichiho, Robles, & Aitaotao, 2013); however,  they have a  smaller population number compared to other ethnicities on Saipan (U.S. Census Bureau, 2010). The theoretical framework in the scholarly literature that grounded this qualitative study was Penchansky and Thomas's (1981) theory of access, which claims that for an individual to experience the best access to care, the individual must achieve the five dimensions of access. Penchansky and Thomas's study analyzed the dimensions of access to health services to see how they impacted rural areas' access to services. In that research, the authors described the theory of dimensions of health care access, which validated the need to ensure that those challenged by health care access are explicitly studied to determine what phenomena and dimensions apply.

According to Penchansky and Thomas (1981), the five dimensions of access are availability, accessibility, accommodation, affordability, and acceptability. Availability refers to a relationship between the volume of resources and the clients' volume and type of needs (Penchansky & Thomas, 1981). I assessed the number and types of health services on Saipan and their operation hours to determine whether they met the Chamorro people's health needs. Accessibility refers to the relationship between the location of the resources and the clients' site (Penchansky & Thomas, 1981). The island topography, the regional area, and transportation mode were discussed in participants’ interviews to understand this dimension. I reviewed how the island's health services organization fitted the Chamorro people's accessibility. Accommodation is the relationship between the organization of the health resources to accept the clients and the clients' perspective on the organization's appropriateness and the organization’s ability to accommodate them (Penchansky & Thomas, 1981). I assessed whether the hours of operation at the different outpatient clinics and the number of health professionals were adequate to see patients on the island. It was also essential to analyze workplace policies that permit and encourage employees to seek primary health care. Affordability refers to the relationship between the price and the discount of health services and how the client can pay for those services (Penchansky & Thomas, 1981). I investigated whether local health insurance, health costs, payment, and options were available. It was essential to determine whether there were barriers to obtaining payment options. I looked for barriers in policies or in an individual's beliefs. Lastly, acceptability is the relationship between the clients and the providers or the health organization and how their perceptions of one another determine access (Penchansky & Thomas, 1981). I interviewed the Chamorro people to understand their perceptions of health care providers and health care organizations. I tried to get an understanding of how the Chamorro people felt about their access to their health care provider and other health services.

## Cultural Diversity in Health and Illness

The other theoretical framework that guided this study was the theory of cultural diversity in health and illness. Per Spector (2002), cultural diversity affects health care, and environmental control, biological variations, social organization, communication, space, and time orientation develop this phenomenon. To see if cultural diversity affected how the Chamorro people access health care services, I assessed each of these factors.

Environmental control is when the individual's health beliefs, locus of power, and culture influences nature and the environment (Spector, 2002). The Chamorro people of Saipan believe in traditional medicine to address their health issues (Torsch & Ma, 2000). The qualitative interviews helped me understand if these traditional beliefs still influenced how Chamorro people access and utilize health care services.

According to Spector (2002), biological variations are the factors in cultural diversity, which include the ethnicity of the individual or the geographical factors of where they live. Therefore, I assessed if Saipan's geographical location brought challenges to Saipan's Chamorro people over time. I also investigated if the Chamorro people considered their unique ethnicity as an obstacle to accessing health.

The language and other social beliefs of individuals are called the social organization of cultural diversity (Spector, 2002). These factors might include familial and religious activities. According to Camacho (2011), Chamorro people have strong familial and religious beliefs, which could drive their culture and daily social activities. To help me understand how Chamorro people access health care, I also needed to examine this factor of social organization.

Communication and its relationship with culture and diversity is the interaction between humans and how human beings influence one another, which affects the way they access health care (Spector, 2002). The Chamorro people's interaction with other cultures historically and currently might have an effect on how Chamorro people access health care. I looked at this interaction to see how health care providers viewed the Chamorro people when delivering health services to them and how the Chamorro people viewed their health care providers.

According to Spector (2002), culture in health influences space, which means what is observed and sensed by the individual in relationship to others. The association is different with each different culture (Ingram, 2012). For the Chamorro people of Saipan, the web of colonialism that existed for years cannot be ignored, especially regarding how the Chamorro people interacted with their colonizers (Camacho, 2011). It was, therefore, essential to see if this concept affected their access to health care.

In regards to time orientation in cultural diversity, it is defined as a culture's view of time, and it can be an effect of the past, current, and future on one's behavior (Spector, 2002). I interviewed the Chamorro people to understand better their historical experiences, current situations, and future views. I explored the concept of time orientation in cultural diversity and examined whether it affected the Chamorro people's utilization and access to health care services.

Just like other ethnicities, the Chamorro people on Saipan have a unique culture. Using the different concepts of cultural diversity described by Spector (2002), which include environmental controls, biological variations, social organization, communication, space, and time orientation, I examined whether each concept influenced the behaviors of the Chamorro people on Saipan. Understanding these behaviors and cultures of the Chamorro people helped explain how they access health care.

## Literature Search Strategy

The literature search strategy was focused on databases accessible through the Walden Library and in Google Scholar. The search was for all articles, reports, and books published in the English language. I also reviewed articles used as references within the articles found in my initial search. An attempt was made to limit the literature to the past 10 years, but due to the limited number of studies on the target population, I included articles that reached back to 1981.

The key terms and combinations of terms I used in the literature search were *Chamorro, Saipan, Mariana Islands, health, access,* and *utilization*. I then added other terms and combinations of terms: *barriers, diabetes, indigenous, traditional, Pacific Island, Trust Territory, native,* and *Islander.* I found no research that explicitly focused on the Chamorro people and their access to or utilization of health care services. There was little research found focusing on delivering health care services on the island of Saipan or the Northern Mariana Islands.

Due to the search's challenge, I then shifted the key terms to focus on other populations, such as Native Hawaiians, Pacific Islanders, Asians, and Native Americans, to proceed with the literature review. From this shift, I found articles that described how cultural perspectives influenced how health care is accessed and utilized and articles that described healthcare access barriers, such as lack of insurance coverage and lack of accommodation for improvement of health care access.

## The Chamorro People

The Chamorro people are the original people of the Mariana Islands (Cunningham, 1992). The Spanish settlers described the Chamorro people as tall (Cunningham, 1992). Peterson (2012) described the Chamorro people as healthy people who built their homes using pillars, called latte stones, that can still be found on the island, standing at about 8 feet and requiring extreme strength.

## History of Saipan

### Colonization

The Mariana Islands were colonized by Spain when Spanish explorer, Ferdinand Magellan, found the islands in 1521 (Bankoff, 2006). During the Spanish era, many Chamorro people were executed or transferred to other islands (Atienza, 2013). The Spanish government later allowed the return of the Chamorro people to Saipan. In 1898, after the Spanish-American War, Spain turned over Saipan and all of the Mariana Islands, except Guam, to Germany (Misco, 2018).). Germany's rule of the islands was short and ended after World War I in 1918 when the United Nations gave the islands to Japan (Misco, 2018).

## The Battle of Saipan

The island of Saipan was invaded in 1944, during World War II, as a strategy to end the war between Japan and the United States (Hughes, 2010). According to Hughes (2010), although the Chamorro people had no stake in the war's outcome, they had to endure the war's entire experience, including injuries and death. The United States took control of Saipan and the other Mariana Islands north of Guam after the Pacific victory in 1945 (Morison, 2002).

## The Trust Territory of the Pacific Islands

In 1947, after World War II, an agreement between the United Nations and the United States placed Saipan and the other Micronesian islands except for Guam under the administration of the Trust Territory of the Pacific Islands, also known as TTPI (McKibben, 1990). According to McKibben, the agreement intended to help the islands become self-sufficient by promoting the islands' economic advancement, fostering self-government, protecting the indigenous people from losing their land, promoting educational progress, and protecting the freedom of its residents. The TTPI treated all the Micronesian territories as a whole. Still, the people on Saipan and the Northern Mariana Islands are different in language and culture from the other Micronesians and, therefore, felt the need to be separated (Hezel, 1978). In 1971, the people of the Northern Mariana Islands voted to remove themselves from the TTPI. In 1976, President Gerald Ford proclaimed the Northern Mariana Islands part of the American soil (Tacupa, 1977).

### United States Citizens

On November 3, 1986, the Northern Mariana Islands were recognized as a territory and became the Commonwealth of the Northern Mariana Islands (CNMI) of the United States (Fields, 1994). President Gerald Ford proclaimed the islands to be "in political union with and under the sovereignty of the United States of America" (Sato, 1975). As a territory, Saipan and the Northern Mariana Islands became part of the United States, and its residents became American citizens and controlled their local government (Pöllath, 2018).

### Geography of Saipan

Saipan's island is located at 15.2123299 degrees latitude and 145.7545013 degrees longitude in the northern hemisphere and close to the Equator (U.S. Geological Survey (2003). This location makes the island prone to typhoons and tropical cyclones (Dickinson & Molinari, 2002). Recent storm activities reached Category-5 strength and appeared more often in a year than in previous years (Chowdhury, Chu, Zhao, Schroeder, & Marra, 2010). Downed power lines and destruction of infrastructure interrupted electricity, food, and water supply on Saipan for months after Typhoon Soudelor hit the island in August 2015 and again after Super Typhoon Yutu hit the island in October 2018 (Jones & Kelleher, 2018).

## Health on the Island of Saipan

### Pre-colonization Health

According to Hattori (2004), pre-colonization health on Saipan and the Mariana Islands was guided by the Chamorro people's beliefs, which was that both the people of before, called taotaomona and the evil spirits, called aniti, controlled their health. The Chamorro people utilized herbs and other plants to treat different illnesses in the islands (Nandwani, Calvo, Tenorio, Calvo, & Manglona, 2008; Tanaka, Gryzlak, Zimmerman, Nisly, & Wallace, 2008). The Chamorro people also relied on medicine men, called suruhanu, or medicine women, called suruhana, to treat any illness that medicinal plants could not heal (Torsch & Ma, 2000).

## Colonization Health

According to Hattori (2004), the Spanish introduced Roman Catholicism to the Chamorro people as a means to reduce the use of the suruhanu or suruhana and eliminate such practices. Eventually, the Spanish colonies left the natives to use their own medicine, and the Spanish administration focused mainly on controlling the spread of diseases with vaccinations (Reyes, 2014). During the German-ruled era, the colonized territory's health system was almost nonexistent, and health care services catered to the Germans living in these colonies (Wessels, 2018). According to Hattori (2004), in the Japan-ruled era, the Chamorro citizens were given more freedom and left to freely carry their traditional medicine practices.

## Post-War Health System

When the United States defeated Japan after Saipan's invasion, the United States military took responsibility for all captured people's health and placed the Chamorro peoples in concentration camps (Trefalt, 2009). According to Trefalt, American soldiers built tent hospitals and provided basic health care for the Chamorro people. The Chamorro people utilized traditional medicine less frequently since the bombings destroyed vegetation on the island and limited medicinal and herb plants (Willsey, Kwon, Reeves, Amidon, & Miller, 2019).

## Trust Territory of the Pacific Health System

In 1964, all islands in the Marianas, excluding Guam, were part of the government of the TTPI. Under the TTPI, the United States subsidized the island's health system (Fitzpatrick-Nietschmann, 1983). According to Fitzpatrick-Nietschmann, the first hospital and medical clinic was built for the local people on Saipan during the TTPI administration and named it after Dr. Jose Torres, the first Chamorro medical officer. Health care for the Chamorro people continued with traditional medicine, village elders, physicians, and nurses from off-island (Abbas & Person, 2008). For the more complicated health services and procedures not performed at the Dr. Torres hospital, the State of Hawaii provided them as part of a humanitarian project, called the *Pacific Islands Health Care Project* (Abbas & Person, 2008). According to Abbas and Person, the philanthropic project provided health care services and consultation via medical referral or telemedicine.

## United States Territorial Health System

On November 3, 1986, the CNMI became the United States' fifth territory by being a commonwealth and a United States protectorate (Fallon, 1991). The health system consisted of the Commonwealth Health Center Hospital and the Department of Public Health and mental health (Feasley & Lawrence, 1998). The government built a hospital that was a Medicare-certified inpatient and outpatient facility to serve a population of 14,549 people living on Saipan, Tinian, and Rota islands (Ichiho, Robles, &

Aitaotao, 2013). However, the hospital still didn't meet all the population's health needs as some essential services, such as those provided by an eye clinic, were unavailable (Ichiho & Aitaoto, 2013). According to Feasley and Lawrence, the hospital provided primary health care services under this health system, and offshore providers provided all secondary and tertiary care. Because of this constant unavailability of services, the Northern Mariana Islands' health system was considered unreliable but acceptable. According to Ichiho and Aitaoto, improvements to the health system were not tangible because funding was insufficient for health system operations. It was a fragmented health system, and there was a lack of continuity of care (Ichiho & Aitaoto, 2013). Coordination of care between the hospital and other health system services was nonexistent (Ichiho et al., 2013). The Northern Mariana Islands dealt with high morbidity and mortality rates and low vaccination rates for adults (Luman et al., 2007). Diabetic end-stage renal disease is exceptionally high among the Chamorro people in the Northern Mariana Islands (Syed, Hilmer, Imran, Peter, & Robert, 2005).

## Literature Review Related to Key Variables and Concepts

According to Rosario (2010), the Chamorro people do not willingly access healthcare services. Despite their small population number compared to other ethnicities on the Saipan (U.S. Census Bureau, 2010), the Chamorro people have experienced higher incidences of diseases (Rosario, 2010) and mortality rates (Guerrero et al., 2017). Understanding the Chamorro people's culture on the island of Saipan would help us understand how it affects their access and utilization of healthcare services. For this research, I reviewed literature that included studies that used Penchansky and Thomas's theory that the five dimensions of access must be achieved for an individual to experience the best access to care (Penchansky and Thomas, 1981). There is also literature that included the theory that cultural diversity of health and illness developed by environmental control, biological variations, social organization, communication, space, and time orientation influences how health care is accessed (Spector, 2002).

## The Chamorro People on the Island of Saipan

The Chamorro people on the island of Saipan are unique from other Chamorro people on the Marianas archipelago islands. Pietrusewsky et al. (2014) described the factors that included the lack of resources and vulnerability to natural disasters as attributing to the health of the Islanders in the Mariana Islands. Access to water on the islands, for example, is different from each island on the Marianas archipelago. Also, according to Pietrusewsky et al., there is evidence that Saipan's geographical location is more susceptible to storms and drought than the other islands. There was also evidence to show that these geographical challenges contributed to the indigenous people’s high-stress levels.

The history of colonialism on the island of Saipan was also essential to my research. According to Dye et al. (2018), the factors of colonialism, power, and balance in the human-environment contributed to the diabetes health issues of Pacific Islanders. Dye et al. studied the Pacific islands' historic environment, such as the use of traditional medicine for all illnesses. While the challenges of access specifically on the Chamorro people on Saipan was not the focus of the study, I found a linkage between the environment and the health of Pacific Islanders overall.

## The Dimensions of Access

To guide this study, I reviewed the literature on how the dimensions of access influenced other Pacific island populations. According to Zelaya, Galinsky, Simile, and Barnes (2017), one needs to achieve the dimensions of access to obtain improved access to health care services. For example, care and health insurance coverage affected health care access and utilization among Native Hawaiian and Pacific Islanders in the United States (Zelaya et al., 2017). According to Zelaya et al., delaying care and having emergency visits was expected with the Native Hawaiian and the Pacific Islanders in the United States because of care costs.

One of the dimensions of access that I examined to determine if it was applicable to the Chamorro people on the island of Saipan was acceptability. According to Lee and Lee (2018), the acceptability dimension, that includes cultural beliefs, can create barriers to care. The attitudes and behaviors among Chamorro people on the US island territory of Guam were significant to the access and utilization of health care (Balajadia, Wenzel, Huh, Sweningson, and Hubbell, 2008). An example of one of these attitudes included accepting that God causes cancer and that their faith in God will help them (Balajadia et al., 2008). It was, therefore, significant to determine if the Chamorro people on Saipan had similar attitudes towards illnesses, and if those attitudes had an effect on their health access.

The lived experiences of Chamorro people on the island of Saipan are also different than the Chamorro people on the island of Guam, as each island has significantly different colonial histories. Therefore, it was essential to have a quality and specific study to understand the access and utilization of health care for the Chamorro people on the island of Saipan. With qualitative research, past experiences that may have contributed to how the population perceives the overall health system could help us understand how the dimension of acceptability influences access (George et al., 2018).

Another health access dimension that I examined to see if it was applicable to the Chamorro people on the island of Saipan was affordability. According to Zuckerman et al. (2004) and Zelaya et al. (2017), insurance coverage is a factor within vulnerable populations when accessing health care services. In a study of American Indians/Alaska Natives by Zuckerman et al., only about half of uninsured accessed health care services. Although that population was different than those in this study, the vulnerability of the two populations is very similar.

The other health access dimensions that I examined to determine their applicability to the Chamorro people's access to health care were the dimensions of accessibility, availability, and accommodation. An example of how this might be applicable was how Pacific island veterans living in rural areas did not obtain mental health care services in Pacific island rural communities (Tsai et al., 2014). According to Tsai et al., a lack of understanding of how the health care system worked in the veterans health system strongly influenced how the veterans access services. Experiences in delay and personal costs frustrated and unmotivated veterans to pursue further care from the veterans health system, despite the health care system benefits (Tsai et al., 2014). Therefore, to improve access to care, providing the means to navigate the health system was deemed critical.

## Cultural Diversity in Health and Illness

Focusing on the theory of cultural diversity in health and illness, I reviewed several literature pieces to see how cultural diversity influences how health care is accessed. Cultural diversity has a vital role in the access and utilization of services and the delivery of health services for a population (Blankenau et al., 2010). According to Spector (2002), environmental control, biological variations, social organization, communication, space, and time orientation are the different concepts to cultural diversity in health and illness.

One of the concepts of cultural diversity that influences how the Chamorro people access health is environmental control. Per Spector (2002), the individual's health beliefs, locus of control, and culture environmental control influence nature and the environment. On the Pacific islands, the use of traditional indigenous healing practices for imbalance and illness is still vital (Struthers & Eschiti, 2004). According to Struthers and Eschiti, when a patient is ill, there is an existing belief that the cause may be due to the spirits. The Chamorro people also believe that traditional healing methods provide curing power over these illnesses (Balajadia et al., 2008).

Another concept of cultural diversity is biological variation, which considers the individual's ethnicity and the factors of where they live (Spector, 2002). The Chamorro people on Saipan, like other Pacific Islanders, experience extreme weather events that force adaptation to the risks associated with the changing environments frequently (McIver et al., 2016). After a severe weather event, the destruction often displaced individuals, and access to health services is often restricted or unavailable (Eckenwiler, Pringle, Boulanger, & Hunt, 2015).

Social organization, which is the language and other social beliefs of individuals, is another concept of cultural diversity that affects health access (Spector, 2002). The Chamorro people have strong familial and religious beliefs that drive their culture and daily social activities (Camacho, 2011). These activities include fiestas honoring their villages' patron saints, helping out in 18 days of rosaries for the dead, and 9 days of novenas are a part of the Chamorro social beliefs and are of highest priority (De Frutos & De la Rosa, 2012). According to De Frutos and De la Rosa, the rituals are vital to the Chamorro people's social organization and their extended families and may affect health utilization.

Communication, another concept of cultural diversity, is the interaction between humans and how they influence one another (Spector, 2002). Indigenous populations often require significant trust and a strong relationship with their medical provider to access health care (Denison, Varcoe, & Browne, 2014). According to Kokanovic and Manderson (2007), having a supportive health provider is essential to a positive patient relationship. A positive relationship between the Chamorro people and their health providers should help with the navigation of the health system and improve access to health services (Czapka & Sagbakken, 2016).

According to Spector (2002), the space concept means what is observed and sensed by the individual when it comes to relationships with others. When a patient whose culture is different from their medical provider, how health care is accessed may be affected (Ingram, 2012). In a primarily Caucasian provider-health system, patients from another ethnicity received care differently from their medical provider, and culture played a role in health care utilization (Hawley & Morris, 2017). For the Chamorro people, there is a shame culture in their society that can prevent having a one-to-one conversation with their provider (Rosario, 2010).

There is also the concept of time, which is the past, current, and future, that may have an effect on an individual's behavior on how they access care (Spector, 2002). The Chamorro people's historical experiences, present situations, and future views may affect their utilization and access to health care services (Rosario, 2010). The Chamorro people's historical experiences show segregation of health care services when under any colonial rule (Pietrusewsky et al., 2014). According to Pietrusewsky et al., the Chamorro people were treated as primitives when providing health services. This treatment and other historical experiences might have influenced the indigenous peoples' current behaviors when accessing and utilizing health services (Suite, La Bril, Primm, & Harrison-Ross, 2007).

Cultural diversity is essential to health care access. According to Torsch and Ma (2000), it is vital to provide a cross-cultural comparison between the different Pacific island populations. A cross-cultural comparison could help explain health perceptions, concerns, and coping strategies. Utilizing cultural diversity concepts of environmental control, biological variations, social organization, communication, space, and time orientation might help with this comparison (Spector, 2002). Health providers could then accept these differences between Pacific island cultures and incorporate these differences in healthcare delivery (Torsch & Ma, 2000).

## Summary and Conclusions

The Chamorro people of the Northern Mariana Islands are known to have very poor health. A study on what may have contributed to this problem included researching how the Chamorro people of Saipan access and utilize health care. A literature search strategy was necessary to begin the research and identify the theoretical frameworks of health care access and culture diversity in health and illness.

The literature's major themes were that access to health care is an issue of concern in vulnerable populations. While there are different access dimensions, there was a similarity for each vulnerable population identified in the chosen literature. The cultural differences (Lee & Lee, 2018), lived experiences (Blankenau et al., 2010), the perceptions of the health providers and the health system (Tsai et al., 2014), and the knowledge of how to utilize and navigate the health system (Czapka & Sagbakken, 2016) contain the different access dimensions. Each literature provided evidence that a qualitative study was needed to understand how these factors affect a population's access to care. While the literature review did not identify a study that shows how the Chamorro people on Saipan explicitly access health care, there was literature support that described how the government delivered health system historically and currently on Saipan. These findings could help determine how the Chamorro people on Saipan access and utilize health care.

The literature selected supported the need for a qualitative study that sought an in-depth understanding of the Chamorro people's experiences on Saipan regarding their access and utilization of health services. The literature also supported the need for qualitative research that uses a one-on-one interview to obtain the phenomenon that drives how health care is accessed. By truly understanding this phenomenon that affects the Chamorro people's health access, we could help make the social change for this population. In Chapter 3, I discussed the methodology used in this study to help understand how the Chamorro people's experiences and culture on the island of Saipan affect their access and utilization of health services.

# Chapter 3: Research Method

In the preceding section, current literature supported the need to have a qualitative study to see how a specific population accessed care (Balajadia et al., 2008; Lee & Lee, 2018; Zelaya et al., 2017). The purpose of this qualitative study was to gain an in-depth understanding of how the experiences and culture of the Chamorro people of Saipan affect their access and utilization of health services. The literature review supported this study in which I used one-on-one interviews to obtain the Chamorro people's experiences with access to, and utilization of, the health system. Understanding this phenomenon among the Chamorro people could help support health administrators develop strategies to improve access to this specific population and improving their health outcomes.

In this chapter, I explain the research design and the rationale for that design. I also describe the research questions, the role of the researcher, and the methodology. I explain the sampling strategy that I used and the steps I took to ensure the participants' rights to confidentiality and privacy to be comfortable sharing their experiences with the health system. Lastly, I discuss issues of trustworthiness and then close the chapter with a summary.

## Research Design and Rationale

The research questions that guided this study:

1. What are the lived experiences of the Chamorro people of Saipan with availability, accessibility, accommodation, affordability, and acceptability of health care services on the island?

2. What are the lived experiences of the Chamorro people of Saipan with the environmental control, biological variations, social organization, communication, space, and time orientation of the health care services in Saipan?
3. How do the cultural factors of environmental control, biological variations, social organization, communication, space, and time orientation impact the lived experiences of the Chamorro people of Saipan with availability, accessibility, accommodation, affordability, and acceptability of health care services on the island?

In this study, I sought an explanation or meaning through participants’ lived experiences (Moustakas, 2001) that should explain the phenomenon of how Chamorro people accessed health care services. A qualitative study helped me gather the participants’ recollection of events that included the participants' tone and mood and not just the answers to the interview questions (Moustakas, 2001; Patton, 2015). According to Patton (2015), it was essential to gather information about individuals' experiences and look for commonality to explain the phenomenon. A qualitative study helped me learn directly from the Chamorro people on Saipan about their past and current experiences in accessing and utilizing the health system.

The research design was a phenomenological heuristic inquiry. This approach allows researchers to explore how a phenomenon of experiences affects the behaviors of a population (Moustakas, 2001; Patton, 2015). The phenomenological heuristic inquiry immerses the interviewer into the participant's experience and helps the interviewer get clarity and meaning of those experiences (Moustakas, 2001). The result was an actual illustration of the experiences that could help explain the phenomenon and the behaviors of the participants (Moustakas, 2001; Patton, 2015).

The rationale for conducting a heuristic phenomenological study was that it would help me get the participants' perspectives of their lived experiences and what they felt of that event and not merely describe those experiences (Moustakas, 2001). The phases in the heuristic inquiry approach helped me achieve that. As an administrator of the health system, I did not truly know what prevents the Chamorro people from accessing health care services. The phenomenological approach helped me obtain an in-depth understanding of the Chamorro people's experiences with Saipan’s health system and how that affected how they accessed health care on the island of Saipan.

## Role of the Researcher

As the researcher in a qualitative inquiry, I had the responsibility to be the main instrument for collecting the answers to the research questions (Patton, 2015). According to Patton, readers can perceive the findings of my inquiry as trustworthy, and it was essential to present myself during the investigation in that manner. According to Patton, I needed to show empathy and be culturally sensitive while also emanating my skills, experience, and competency during the interview.

It was important to recognize my own biases early and before conducting the study (Merriam & Tisdell, 2016). Because I am a Chamorro who lives on the island of Saipan, there was a potential bias in the interview process, including data collection and analysis. I utilized the reflexivity strategy that allowed me to self-reflect at each phase of the research process. Reflexivity enables researchers to make a critical self-reflection regarding assumptions, biases, and their relationship to the study (Merriam & Tisdell, 2016). I also utilized a peer review of the research. According to Merriam and Tisdell, one way to guard against biases is to have a peer review of your data and analysis. The peer reviewer was an experienced qualitative reviewer that I recruited. The reviewer signed a confidentiality statement to protect the participants' privacy. I also had the participants review their interview responses and validate them to ensure that my documentation of their responses was not subjective. According to Merriam and Tisdell, member checking or participant validation ensures the researcher's interpretation of the participant's answers are accurate.

As one with direct experience with Saipan's health system, I used the epoche and bracket process as another means to address my bias (Merriam & Tisdell, 2016). I needed to refrain from putting my assumptions ahead of the study and, instead, set aside what I thought and believed would affect the participants' behaviors. It was a process that I was comfortable with because of my personal experience being in a leadership role at a health system that employs over 500 Saipan residents. To further mitigate bias, I asked the questions as scripted while conducting the interview. According to Merriam and Tisdell, how I showed myself in the interview, such as having a neutral stance and avoiding asking leading questions, minimized bias.

As the researcher and the head of the CHCC, the only hospital and the health agency on the island of Saipan, I needed to exclude individuals employed by the CHCC. CHCC employees, even if advised that the study was independent of their employment for the hospital, might be uncomfortable participating freely in the research study. They might fear that how they responded could lead to punitive employment outcomes. Also, they might not be willing to share their experiences with the health system, their employer. However, I included their immediate families if they showed that they volunteered to participate independently, and the employee did not recruit them to participate in the study. As the researcher, I had to develop trust with all the participants, including the employees' family members. To ensure this, I provided disclosure of what I do, and I assured participants that my role as a researcher was independent of the research study.

According to Patton (2015), it was also essential to conduct research ethically. I held the participants' recruitment and interviews outside my organization to ensure that I did not use my employer's resources. I distributed flyers and sent e-mails outside my working hours and the organization's facilities to recruit participants. Those employees aware of my research who wanted to assist in this study helped recruit participants. However, they did so outside of working hours, and I only discussed my research after working hours.

## Methodology

### Participant Selection

The population for this study consisted of Chamorro people who live on the island of Saipan. I used the purposeful sampling method to obtain individuals who met the needs of the study (Patton, 2015). The sampling strategy I selected was homogenous purposive sampling. According to Patton, this strategy provides the researcher with a specific sample of the population that meets the study's purpose. The target participant selection for my research was a Chamorro adult over 18 who lives on Saipan. The participants had experiences accessing health services on Saipan; however, they did not have to be active patients of the hospital or the health system. Although I asked the participants if their payer status was insured or uninsured, their payer status was not a principle for participation.

I interviewed 12 participants, and I anticipated that this number of interviews would result in the achievement of data saturation, in which the data that support the study was adequate and of quality (Walker, 2012). According to Mason (2010), saturation is dependent on your phenomenological approach and the purpose of your study. In a heuristic inquiry, the number of participants needed for saturation will range from as low as seven to as high as 89. For this study, the sample size I selected seemed reasonable for the specific characteristics of the participants. The sample size did not change as I collected the data, and I achieved saturation after I organized the first sample size data.

## Instrumentation

The data collection instrument I used was one that was appropriate for this study and other qualitative studies in which researchers seek to get in-depth information on lived experiences (Conway, Lawn, Crail, & McDonald, 2018). Face-to-face semistructured interviews allow the researcher to observe while hearing the stories of events and experiences directly from the participants (Al-Busaidi, 2008; Makagon & Neumann, 2008). Before conducting the interview, I developed a practical interview guide, which was essential to a successful qualitative interview (see Morris, 2015). According to Creswell (2014), interviews allow the researcher to understand the target population's perceptions and experiences. Researchers commonly used semistructured interviews, observations, and analysis of qualitative research documents that were healthcare-related (Al-Busaidi, 2008). The interviews were semistructured and open-ended. The interviews were audio-recorded and then transcribed (Creswell, 2014).

I developed the interview protocol to gather data to answer the research questions. I designed the interview questions and the interview guide (see Appendix A) based on the information collected from the literature review on how other researchers gathered information about their target population's experiences. I also did this to obtain an in-depth understanding of the participant's health system experience.

## Pilot Study

Before recruitment, participation, and data collection for the main study, it was essential to conduct a pilot study that provided me, the researcher, an opportunity to try out the data collection method (Merriam & Tisdell, 2016). I completed a pilot study to see whether the data collection method was adequate and effective. I recruited Chamorro people from Saipan that I knew personally, but I excluded them as actual participants in the main study because of some conflict. After I received their consent, I recorded the interview using the audio-tape recorder to review the process and made any revisions in the main study. As stated in the IRB application, this process was considered a road test of the actual interview process, and I did not report the pilot study results.

### Recruitment, Participation, and Data Collection

As soon as I obtained approval from the IRB at Walden University (Walden IRB Approval 06-17-20-0664623), according to the dissertation guideline of Walden University (2018), I began recruitment. According to Patton (2015), the IRB committee is responsible for assuring human subjects' protection used in research. Since I was interviewing the participants about their personal experiences, IRB approval was necessary.

To recruit participants for my study using the sampling strategy and the criteria selected, I prepared and distributed flyers via a social media platform. I also e-mailed my contacts, asking them if they could share the flyer with their contacts. Once an interested participant contacted me, I screened them (see Appendix B) to ensure they met the criteria for participation in the study. I sent them the informed consent form via e-mail to review before the interview and scheduled the interview's location and time. I informed them that we would go over the consent form together and that once the participant signed the form, we began the interview. Because this research was about access, it was significant to make the interview accessible as well. Public transportation was not ideal for the participants as it only went to limited specific routes and was still not the most preferred means of traveling within the island. According to the U.S. Census Bureau (2010), 52% of the population in the CNMI fall below the U.S. poverty guideline. Therefore, I provided a prepaid gas voucher of not more than $5 to the participant after completing the interview to help offset the travel cost to the interview location. I informed the participants of this reimbursement as I went over the consent form with them. According to Klitzman (2013), compensation to pay for expenses of the participants was considered reasonable.

I prepared flyers to recruit participants for my study using the homogenous purposeful sampling strategy. I also e-mailed my contacts, asking them if they could share the flyer with their contacts. Due to the COVID-19 pandemic, which required the practice of social distancing, I also posted the same flyer on social media. Once an interested participant contacted me via e-mail to my school e-mail address, I screened them, using the screening procedures on (Appendix B), to ensure they met the study's criteria for participation. After the screening, I sent them the informed consent form via e-mail, fax, or attachment to a social media platform, such as WhatsApp, to review it. I scheduled the interview location and time, either in person with social distancing, wearing a mask, and other appropriate precautions, or via video conferencing or telephone, whichever the participant preferred. I considered that some might not have access to a phone or video conferencing. Therefore, some interviews were done in person, practicing social distancing, and wearing a mask. We took all the appropriate precautions to ensure the health and safety of the participant and myself. For those interviews in-person, I went over the consent form together with the participant, and once the participant gave their consent in writing, I started the interview. For those interviews using video or phone, I asked that the participant send me back a signed consent form a day before the scheduled date of the video or phone interview. They sent it back to me via e-mail or pickup. The screening process started right after one showed interest in participating. I conducted the interview right after the participant met the eligibility to participate. I achieved an adequate number of participants for this study.

## Data Analysis Plan

In qualitative research, data management involves storing, transcribing, and coding. The Microsoft Excel document was already available and could be utilized immediately as a spreadsheet to store data and log all the pertinent information I gathered from the interviews. The retention period of these documents is five years after completing the research, which is the minimum required by IRB.

Once I collected all the data, I needed to make sense of the data by consolidating, reducing, and interpreting the data (Moustakas, 2001). I transcribed the data, which was a crucial step to making sense of it all. Depicting the experience was a critical step of the heuristic inquiry and validating the interpretation (Moustakas, 2001). I did this in the words or phrases that responded to the research questions (Moustakas, 2001).

Coding segregates your data to become more manageable and easily retrievable (Saldana, 2012). I coded the data collected from each transcribed interview (Jones et al., 2019). I used the method of structural coding that codes question-based responses. According to Saldana (2012), structural coding is appropriate for interview transcripts with answers to open-ended questions. I chose this method of coding because of the study's framework and the selected research questions. Once I completed my first-cycle coding from categorizing them into themes, I used second-cycle codes to link them to theoretical codes.

According to Patton (2015), the technological advances of current qualitative software for data management and analysis had made it easier for the researcher to ensure adequate data collection, documentation, and retention. Computer-Assisted Qualitative Data Analysis Software (CAQDAS) efficiently stored, organized, managed, and reconfigured the data I collected from the interviews (Saldana, 2012). It also provided convenience and efficiency so that the researcher could ensure validity and more timely completion of data analysis (John & Johnson, 2000). The use of a CAQDAS, an electronic spreadsheet, was beneficial to me. Ultimately, the product I selected was NVivo by QSR International, which enabled me to ensure my research was credible, transferable, dependable, and confirmable.

## Issues of Trustworthiness

Fundamentally, qualitative research is subjective and prone to researcher bias as it uses the researcher to gather information (Chenail, 2011). The researcher's responsibility is to ensure that the research process and the research findings have established credibility, transferability, dependability, and confirmability. Therefore, as a qualitative researcher, I implemented appropriate strategies that were an essential step to building trustworthiness.

It was significant to recognize my own biases early and before conducting the study (Merriam & Tisdell, 2016). As a Chamorro who lives on Saipan, there was a potential bias in the data collection process, including data collection and analysis. According to Merriam and Tisdell, one way to guard against biases is to have a peer review of your data and research. The peer reviewer was an experienced qualitative reviewer that I had worked with. The reviewer signed a confidentiality statement to protect the participants’ privacy. I also asked the participants to review their interview responses and validate them to ensure that my documentation of their responses was not subjective. According to Merriam and Tisdell, member checking or participant validation ensures the researcher’s interpretation of the participant’s answers are accurate.

### Credibility & Transferability

To ensure the credibility of the research, the process of triangulation was crucial (Merriam & Tisdell, 2016). Researchers cannot capture the exact truth. However, triangulation could help closely achieve it. The strategy I used involved comparing and cross-checking data collected from the interviews. According to Patton (2015), this process also required member checking, in which I asked participants to verify and validate my recording of their responses. I promptly did this to ensure the participant could recall their answers at the verification time (Merriam & Tisdell, 2016).

Another vital assurance of conducting research was transferability or external validity. According to Merriam and Tisdell (2016), this strategy involves providing enough description of the study so that the readers can try to determine how their situation matches the research and if they can transfer the findings. I provided the details of the setting, the participants, the results, and even the interviews' notes. In this manner, someone conducting similar research could assess if their study was similar to this one.

### Dependability & Confirmability

Dependability in qualitative research is when the study results are consistent with the data collected (Merriam & Tisdell, 2016). The strategy I utilized for my study was the audit trail, which is thoroughly providing in detail the process of researching to replicate the process and obtain similar findings (Merriam & Tisdell, 2016). I offered a narrative of the procedures I took to conduct and complete the study and kept a log of events in the overall research process in a journal. I also followed the protocol for data collection and data analysis in a phenomenological study. Following the protocols would ensure that the research data supports the research (Burkholder, Cox, & Crawford, 2016).

Confirmability is providing a more objective perspective of the study (Merriam & Tisdell, 2016). I utilized the reflexivity strategy to self-reflect on what I had already gathered, including the preexisting biases. This strategy was an essential step that shows the readers that I acknowledged potential biases, addressed them, and enhanced confirmability (Merriam & Tisdell, 2016). I used self-reflection during the process of data collection, data analysis, and coding.

## Ethical Procedures

Obtaining IRB approval occurs with the researcher's assurance following ethical procedures when conducting the research (Walden University, 2018). This process included ensuring that I had gained access to the participants properly (Klitzman, 2013). It also included ensuring that there was no harm to the human participants, and that the data I collected was also protected (Klitzman, 2013).

Since the participants responded to a flyer that I disseminated on social media, no agreement was necessary to gain access to the participants, other than obtaining their informed consent to participate in the study. I treated the participants with the utmost respect, and I informed the participants of the study's topic, the benefits, and risks of participating. I ensured that the participants were aware of all the research processes by obtaining informed consent. I informed all the participants before interviewing them that the interviews will be audio-recorded and that they had options to withdraw from the study at any time.

The process of collecting, managing, and analyzing data, according to Merriam and Tisdell (2016), must be in place before conducting interviews. It was also essential to obtain a signed informed consent form from each participant before the interview. The purpose of the informed consent form was to convey and obtain approval from the research participant to proceed with the interview process (Corti, Day, & Blackhouse, 2000). I asked the participants' permission before recording the interview, and I explained that the recording's purpose was for accuracy. To protect their privacy, when documenting the interviews, I did not use proper names. Instead, I assigned a number and removed all identifiers to ensure I de-identified the participant.

I provided the participants with the assurance of confidentiality. I identified a risk in which the participant might share a story that had not been told to anyone before, and it included past and current struggles with access to health care on Saipan. I secured all data in a password-protected database, and any personally identifiable information was confidential and that only I, as the researcher, have access to the collected information. I shared this protection information with the participant. I implemented steps to ensure I comply with the data retention requirement of Walden University of 5 years after the completion date of the research.

## Summary

The qualitative research I conducted explored how culture and experiences might have affected the Chamorro people on Saipan on how they access and utilize health care services. I described the methods of data collection and analysis that would assure the integrity of my research. Qualitative research is subjective, and the design, methodology, and process of ensuring trustworthiness were essential to protect my research from perceived bias. It was also vital that I provided a means of protecting and doing no harm to the participant and securing the data that I collected.

Once I received approval from the Walden University IRB, I conducted the study. I ensured I followed the plan I described here as I proceeded with the investigation. This research was significant in explaining the experiences of the Chamorro people's health care access. I needed to make sure it was of the highest quality and that it met credibility for sharing. In the next chapter, I provide details of the data collection and data analysis, including the results supported by tables and figures.

# Chapter 4: Results

This chapter provided the findings and detailed summary from interviews with the Chamorro people on the island of Saipan. The purpose of this study was to hear of the experiences of the Chamorro people towards health services and health on the island of Saipan and to see how it affects their access and utilization of health services. The Chamorro people on the island of Saipan have different factors from populations on Saipan and on the other islands in the Mariana Islands that affect their health, such as geography, environmental constraints, and social and cultural networking (Pietrusewsky et al., 2014). For this research, I used the theories of the five dimensions of access (Penchansky & Thomas, 1981) and cultural diversity (Spector, 2002) to understand the Chamorro people's access to health care on Saipan.

In this chapter, I present the results of my study. First, I describe the pilot study and how I used it to strengthen my actual study. I then describe the setting of the interview and the demographics of the participants. I provide the data collection process and the data analysis in detail. Lastly, I provide the support of my analysis and the results of the study.

The research design was a phenomenological heuristic inquiry. This approach looked at how a phenomenon of experiences affect the behaviors of a population (Moustakas, 2001; Patton, 2015). The phenomenological heuristic inquiry immerses the interviewer in the participant's experiences and helps the interviewer get clarity and meaning from those experiences (Moustakas, 2001). The result illustrated the experiences that could explain the phenomenon and the participants' behaviors when accessing health care on Saipan (Moustakas, 2001; Patton, 2015).

I interviewed 12 participants who met the eligibility criteria to get an in-depth understanding of their thoughts and experiences on accessing and utilizing Saipan's health care services. According to Mason (2010), saturation is dependent on the phenomenological approach, and the purpose of my study and the sample size was deemed reasonable for the participants' specific characteristics. I utilized Zoom video conferencing and telephone interviews for the interview process; however, if the participant preferred a face-to-face interview, I ensured that I followed the guidance provided by the Centers for Disease Control and Prevention to ensure the safety of the participant and myself, from getting infected with COVID-19.

## Pilot Study

Before the recruitment, participation, and data collection for the main study started, I conducted a pilot study that provided an opportunity to try out the data collection method (Merriam & Tisdell, 2016) and to determine whether the data collection method was adequate and effective. I recruited two Chamorro individuals from Saipan that met the eligibility criteria to participate. Still, their participation in the main study was considered a conflict due to their relationship with me, the researcher.

I recorded the interviews using the audio-tape recorder in order to be able to go back to the files and review the process. After the interviews, I assessed the processes. I decided that the questions I initially selected were too general and might not achieve my study's data collection to answer the research questions. I then added targeted interview questions to the main research to obtain more in-depth information from the participants.

## The Setting

I conducted this research during the COVID-19 pandemic, in which social distancing was necessary to prevent the spread of the COVID-19 virus in the community. I offered face-to-face interviews as an option and assured the participants that we could conduct it safely. All except one of the participants chose a virtual or telephone setting for the interview. For the face-to-face interview, the individual asked that we interview at their home. We took all the appropriate precautions to ensure the health and safety of the participant and myself. We practiced social distancing outside their home, wore a mask, and had hand sanitizer to clean our hands.

I conducted all interviews during the evenings, on the weekends, and in the mornings. This accommodation was necessary because several participants worked during the weekdays. I made sure that I presented and conducted the interviews professionally. Although I did not experience any technical issues, I made sure to have a backup for the recordings if they arose.

## Demographics

The criteria for participating in this study were that one must be a Saipan resident, of Chamorro ethnicity, and over the age of 18 years. Those who responded to the flyer posted on social media confirmed their eligibility for each of the criteria. Once I validated the prospective participants' eligibility and obtained their informed consent, I conducted the interviews.

I interviewed three men and nine women (see Table 1). Two were unemployed, and all others were actively employed (see Table 1). All participants had utilized the health system once before, as noted in their responses during the interview. During the interview, I found that although all participants had health insurance, some were underinsured. Insurance types included Medicaid, commercial insurances, and military coverage (see Table 1).

Table 1

*Participant Demographics Data*

| Participant number | Gender | Employment status | Insurance status | Insurance type |
|---|---|---|---|---|
| P1 | Male | Unemployed | Insured | Medicaid |
| P2 | Female | Employed | Insured | Commercial |
| P3 | Female | Unemployed | Insured | Medicare/Medicaid |
| P4 | Female | Employed | Insured | Commercial |
| P5 | Female | Employed | Insured | Commercial |
| P6 | Male | Employed | Insured | Commercial |
| P7 | Female | Employed | Insured | Commercial |
| P8 | Female | Employed | Insured | Commercial |
| P9 | Female | Employed | Insured | Commercial |
| P10 | Female | Unemployed | Insured | Military |
| P11 | Male | Employed | Insured | Commercial |
| P12 | Female | Employed | Insured | Commercial |

## Data Collection

After receiving IRB approval, I recruited 12 participants by posting the approved recruitment flyer on my personal page on social media and e-mailing friends a copy of the flyer. These methods of recruitment were necessary to ensure social distancing during the COVID-19 pandemic. The flyer had details about my study and instructed readers to e-mail me if they were interested in participating. My social media friends shared my personal page with others who responded with their interest to participate. Some responded by sending an e-mail, whereas some sent a private message via social media instead, asking for more study details.

For those sending a private message via social media, I asked for their e-mail to send the details, answered any questions they had, and ensured I had a trail of the e-mail conversation. I responded to e-mails promptly within 2 hours. I e-mailed or sent via a phone application, such as WhatsApp, the informed consent form to each participant in advance of the interview. I asked that they reply with an e-mail stating that they consented to the interview.

I used my personal video conferencing account or my cellphone for the interviews, combined with a tape recorder to record the interviews. I informed each participant that I would be recording the interview, and once I obtained their consent, I began to record. Because I offered the incentive of a $5 prepaid gas voucher for the interview, I made arrangements to meet them briefly at a specific public place to deliver those incentives. I made sure that I conducted this in a safe manner that followed the Centers for Disease Control and Prevention guidelines for the prevention of COVID-19 spread.

The interviews took about three weeks to complete because most of the participants were employed and preferred evening hours between 7:00 p.m. to 9:00 p.m. and Saturday afternoons. All interviews took place between July 8, 2020, and July 26, 2020, and I conducted these interviews from 8:00 a.m. to 10:00 a.m. and from 7:00 p.m. and 10:00 p.m. I acknowledged that the time selected for their interview was a reasonable time usually spent with their families. Therefore, I made sure to express my appreciation for their time and that I respected the time spent participating in the interview. Although I allowed at least 2.5 hours for the interview duration to ensure there was ample time for each participant to tell their story, I completed all of the interviews within an hour or less.

## Data Analysis

I used a transcribing application to transcribe my interviews and edited them to ensure accuracy before uploading the files to the 2020 version of NVivo data analysis software (Version 13). NVivo was an appropriate tool to assist with organizing and coding the participants' transcribed responses. I reread the transcribed data and used a two-cycle coding process to reorganize the codes to theoretical coding (Saldana, 2012) in NVivo. Because the questions asked were open-ended, I used the method of structural coding and, subsequently, theoretical coding.

I based the first pass of codes on themes, such as worrying about the cost of going off-island to access care and worrying about what their health insurance will cover. Participant 10, for example, stated, “I travel on my personal expense to Guam for a couple of reasons. One is that the specialty care is not available here”. I linked these and other themes to the theoretical codes of the five dimensions of access and the cultural diversity in health and illnesses.

The examples of first pass codes were barriers to obtaining coverage, the cost of services, and coverage options. In this example, I then coded these to affordability. I eventually coded all first pass codes into all the hierarchal codes of acceptance, accessibility, availability, affordability, accommodation, communication, environmental control, biological variations, social organization, space, and time orientation. I subsequently linked these theoretical codes to the research questions (Saldana, 2012) and the interviews' themes. I explain the analysis further in this chapter.

## Themes

Over time, the participants had different attitudes towards the previous and current health systems. Six of the participants recollected how they received health services at the old Dr. Torres Hospital and the government health department. The participants described how the health system delivered care to the Saipan community. Some recognized the vast improvements in the services, but some were still not convinced that changes were indeed there. There was also a common theme that services are missing or are not easily accessible on the island. The participants must travel off-island to another island or a country close to Saipan to access these services. Still, another theme was family importance. The participants discussed how difficult it was to receive health care away from families and without their support system. Lastly, there was a theme of perceptions from the provider and the participants. These linked the Chamorro people's culture and the extension of accommodation from the health care providers.

## Research Question 1

To learn about the lived experiences of the Chamorro people of Saipan with availability, accessibility, accommodation, affordability, and acceptability of health care services on the island of Saipan, I asked a series of questions (see Appendix A: IQ1-6).

### Health Professional and Services Shortage

Participants had various experiences with the volume and type of health care needs and resources available on Saipan. Nearly all participants accustomed themselves to the shortage of providers, the lack of specialized and local providers, and the lack of diagnostic equipment and services available on Saipan. If these services were not available on the island, the option was that the government of the CNMI sends the patient, or the patient's specimen, to the nearest health care provider or facility that is located off-island and has the diagnostic or treating equipment or specialty provider. The location can be to Guam, a foreign country, Hawaii, or the U.S. mainland. The referral and transfer might not happen immediately, and participants shared their challenges with this process. Participant 1 shared the challenges with the inability to obtain blood work on Saipan,

> I wish that when we get our blood works taken, that the test can be conducted here on island instead of shipping it out because I always worry about an error on my results. Many times, the results will come back and I have to retake my blood work, because according to my doctor, there's probably an error in the shipping.

Participants 2, 3, and 4 shared their challenges with waiting for a referral to a specialist. Participant 2 shared, "I'm still waiting to be referred to a bone doctor to see if they're going to put a needle in it [bones] or what they're going to do with it." Similarly, Participant 4 said, "So I have to go to Guam to do the MRI. I think I had to wait like maybe 30 days just to get a confirmation for an MRI [appointment]." Finally, Participant 3 stated, "I got referred [off-island] for cancer treatment." This may be the most challenging issue to address because cancer treatment typically necessitates multiple courses of treatment, all of which would likely need to be done off the island. Participant 6 stated that

> It was disheartening as the limited services and the limited professional that we have then to tend to come up with and try to diagnose other issues. Other than properly referring it to maybe a much more experienced doctor. But again, not having the doctors onsite is challenging for us here to see it as people and as a community.

Participant 7 summed up the challenges of the shortage of health professionals and health services by noting, "For me personally, to get to see a specialized doctor, like the bone doctors, our GI doc, or other specialists, those were some of the challenges because I guess we have it limited [here]."

Some participants shared their experiences about making the tough financial decision to get health care access off-island for themselves or their family member, instead of waiting for the CNMI government to act. For example, Participant 2 shared the hardship of her parents:

> I know that my parents, my mom, had to get an advance. I think I remember she took out money from her retirement and things like that to make it happen. And part of it is because of what people would say when my dad left. He was not on medical referral. My mom had to pay for their ticket.

Participant 4 described the stress of waiting for care:

> I'm going to be put on hold and wait until we address how long would it take for me to get into referral and all of that. So my husband and I thought about it and he's like, okay. The primary [providers] refers us to Guam. We have our private insurance that accepts it. So we ended up just paying for our ticket and paying for the hotel and transportation. But for us who can afford it, it brings some peace of mind to me, especially as the patient and my husband. And when you're dealing with cancer, it's like three months is a long time or two months…So it is very stressful.

Participant 6 shared how their family came together to help their mother access care she needed off-island:

> It's very disturbing because we had to sit down as a family to make a decision. We know what's going on. We did our own research, but her cancer, we were told that her cancer was very erratic. So we took it upon ourselves and after she left, she never came back for about a year. She stayed about a year to get the treatment.

Participant 10 described how she handled her access to care:

> So for the majority of my health care access, I travel on my personal expense to Guam for a couple of reasons. One is that the specialty care is not available here in the CNMI and the other it would be cost effective for me. I am a military dependent, so all my health care costs are zero.

Participant 3, who was leaving the island to obtain cancer treatments, needed to make a quick financial decision, or she would have to travel off-island alone. She said, “Everything was okay according to plan. But when my escort arrived at the airport, she had no ticket. It was not purchased. So immediately I purchased the ticket for her.”

Participant 11 literally “had to pick up their [lives] and live in Guam” because her “mom had breast cancer” and the treatment wasn’t available on Saipan. She stated, “my dad took care of her for like a year. She wouldn't have to do that if she got the treatment at the hospital here.”

When doctors were available, several participants had difficulty getting access to health care. Participants talked about how they would wait weeks or even months before getting an appointment with a provider or for a diagnostic test, reflecting the shortage of health services and healthcare providers on the island.

Participants 2, 5, 6, and 8 shared their challenges with getting an appointment to see a provider. Participant 2 said, “Well, they're booked. They’ll say, sorry. They're not seeing anyone, any new clients, even former clients, because their workload is heavy.” Similarly, Participant 5 also shared that there was “The long wait for the appointment and then the long wait to see the actual doctor”. Likewise, Participant 6 stated, “I can come in early morning and it may be hard to get seen, because of the number of our people that are also seeking the same assistance.” Lastly, Participant 8 said, “And it's the waiting period that I don't like. Waiting for your appointment or waiting at the clinic or waiting to see the doctor.”

Participant 9 summed up a process she experienced for making an appointment:

> I have to fall within when their next available [appointment]. I'm blocked out for an appointment, especially they're still like booked months in advance, so they have to wait for the next month schedule to see who's available and when.

Three participants expressed the lack of a doctor-patient relationship because of the shortage of stable healthcare providers and their health care providers frequently changing because they moved away from Saipan. Participants described the relationship as not welcoming.

Participant 10 said, “You see a different doctor every time. So it's a little bit more difficult to be open about my healthcare needs with that kind of system.”

Participant 1 shared his experience of constantly getting a new provider:

> I've been a client in Saipan and it felt like every time…they'll be around for two years and then they leave and maybe then we have to wait for another one to come in. So it's always a constant [process of] going over my history with a new doctor. It's like, there's no patient-doctor relationship because they're still getting to know me. That's why this doctor was perfect because he was local and he stayed around.

Participant 2 described how it worried her when her provider left:

> Like she moves up from there and goes to another area. And I already have established our relationship as a patient and doctor, but because she was doing that, I just kind of let go of getting checkups and doing follow-ups because she's going to leave. And who's going to follow through with my checkup? Who's the doctor that I can establish a relationship again?

The lack of providers led to the emergency room rather than going to a primary care provider. This reaction was because the pain was no longer bearable, or the provider had not resolved their medical issue.

Participants 4, 8, and 10 briefly described their situation when this happened. Participant 4 shared that “Unfortunately, that's the second attack came the night before I couldn't stand the pain. So, I had to go to the ER. So, I just went in and got pain meds.” Similarly, Participant 8 said, “the last time I went to the ER was when I was having back pain.” For Participant 10, she used the emergency room as access “because that is the only other clinic or hospital that would be available at that time.”

When the participants finally could get access to a provider, some stated the wait time to see a provider was a significant factor.

Participants 2 and 8 summed up their experiences, “I think more of, there's lack of doctors. So we have to wait a long time to be able to set up an appointment with them because it's back to that.” Participant 8 indicated that “I'm making the time to go and make the appointment...and it's the waiting period that I don't like. Waiting for your appointment or waiting at the clinic or waiting to see the doctor.”

Participant 6 shared his understanding of the long waiting time:

> Wait time is an issue. Because the ER, or the facility is small. So, you know we have the only hospital. Everyone gets seen at CHC. So if [there’s] an emergency you know ambulance comes in, that will be a wait. Like [even] for my knee, unless I'm in and there's a change in my condition then, of course, that changes the priority.

Participant 10 explained how going elsewhere for care was due to short wait times:

> I primarily go to a private clinic. Only the wait time is much shorter. I can walk in without an appointment. And that's a big factor for minor ailments, just needing over the counter medication and stuff like that. The wait time is a big factor for me.

Once they had the provider visit, they felt rushed, and they suspected it had to do with the large number of patients waiting to be seen. Participant 6 explained, “some rush because one I feel that, when you come to the healthcare facility there's a lot more people than you expect. So the doctors want to see you and get you out as, as quick as possible.”

Participant 2 explained her experience:

> And at a certain point, because they're busy, I just feel like they're rushing, like, get this here. I have a timeline on this and there's no extra step of finding out more, a little bit about the patient. And that's what I've noticed at least a year and a half.

Participant 11 shared a similar experience:

> It takes hours, especially in the emergency room. If it's not a real emergency, of course, they're going to put you, I guess, the priority of how well your problem is. I guess it's the waiting. And then when you go to see the doctor, you only see them in five minutes and then it’s done.

## Research Question 2

Research question two focused on the Chamorro people of Saipan's lived experiences with environmental control, biological variations, social organization, communication, space, and time orientation of the health care services in Saipan. I asked a series of questions (see Appendix A: IQ1-6).

### Historic, Current, and Future Access to Healthcare Services

The participants' communicated their experiences with health care access over time. The participants were able to recall positive and negative experiences over time when accessing health care on Saipan. Some described their current access to care, while some described how and why access to care in the future. Some spoke of their own experiences, and some were of those they witnessed happened to their family members.

Participant 3 described an experience of receiving care at the old hospital, the Dr. Torres Hospital and said, "The only time that I remember visiting Dr. Torres hospital was when I broke my arm."

Participant 7 recalled visiting the hospital as a child:

> I was brought by my father to Dr. Torres hospital. What was happening was every morning as a child, I was having like joint pains. And I'm trying to recall how bad they were, but it's like, I couldn't move. My walking was difficult at times. And so they brought me to Dr. Torres and, and well, back then, it's easier to come and see a doctor, and there's not a lot of people that are here, so I can't recall his name, but they ran some tests and they came back and told my dad, I had rheumatic fever.

Participant 8 also recalled her visits to the hospital:

> When we get sick, our parents who would take us to the hospital, which is, it was Dr. Torres hospital before. And we get checked at whatever medication and stuff like that, but yeah, we do go to the hospital when we do get sick and annual shots.

Participant 1 described a similar type of visit:

> The only time that I've probably got to see a doctor was when my fever was really high or all other ailments. I don't remember of any other ailments that I went through in life, through my childhood that I needed a doctor for. So I don't have any memory whatsoever other than going to the hospital and putting the thermometer under my arm for anyone to determine what my temperature was. During school I went to Chalan Kanoa elementary school and so I remember every year we had a physical examination that the school would bring us to public health.

Participant 2 shared her experience of access and emergency care:

> During that time we didn't have private clinics. So we have no choice…that was my junior year, I went in, because I had my appendix and, it's so funny when the surgeon, the team happens to be your dad's brother and best friend. And they're going to go operate on you. So it's always been positive because it's even though it's my uncles, I wasn't ashamed because they knew how to make an uncomfortable situation, comfortable, but I trusted them. So I was not worried.

Participants expressed the reasons why they access care the way they currently do or why they avoid accessing health care.

Participants 1 and 3 shared their experience of being very engaged in their care. Participant 1 said, “I don't hold back. I have to make sure that all areas of my health is clear with my doctor so that there won't be any contradiction with medications and whatnot. I’m very cautious in that respect.” In the same manner, Participant 3 said, “I need their opinion. I want to get well. So whatever it takes.”

Participants 8, 9, 10, and 12 revealed their experiences were straightforward and not complicated. Participant 8 conveyed, “Sometimes I go every year, sometimes I skip like a year. It depends on how I'm feeling.” Likewise, Participant 9 said, “Because it's already with the doctor, my annual follow-up or whatnot, then it's easier for them to schedule it. And so, yeah, I haven't had any issues since then, except for when I do have to reschedule for whatever reason.” Participant 10 said, “I can walk in without an appointment. And that's a big factor for minor ailments, just needing over the counter medication and stuff like that.” Also, Participant 12 shared, “I've never really had any difficulty in terms of accessing primary care with our local hospital. Overall, my experience, I feel like it's been so much better.”

Participant 2 shared her experience of intentionally delaying her care:

> I know I'm going to be having this thing, but I guess I know that's life, but it was just the way and the approach. So he goes, well, we need to do your blood work. I said, yes, I'll do my blood work, but I'm delaying the blood work because I don't want to see him.

Participant 6 shared how he didn’t access care after what happened in the past:

> I had to think twice to access care. Am I really going to get the care that I need because of what I went through? I try to tell myself that it was a cancer issue, but at the same time, many occasions, I just wait until, I'm really in pain to access care because I don't want to wait. I don't feel that when I go in, I will be given the care that I needed. It's more, self-diagnosing and it's bad.

Participant 7 explained how s/he changed their access because there was a faster option:

> So we kind of, in those previous years, like many years we stuck to [provider] because one, we didn't have to wait. So we didn't have to wait long to get seen, and I know it's changed. And so our insurance also required us to have one. So we decided, my family decided, that in order to get a quicker visitation with the doctor, it's easier for us to go to a smaller clinic because we need that one-to-one interaction.

Some described how the health system had traditional medicine and how they utilized it first to treat minor ailments. Some participants utilized the services of the hospital only for major illnesses and injuries.

Participant 1 shared his experience using both health system and traditional medicine:

> It was my parents that determined whether I needed to go to the hospital or not. At my teenage years, it was my parents that determined whether or not I need to see a doctor, like for example, I broke my wrist and instead of going to a doctor,

we went to a witch doctor. The witch doctor apparently put my bones together. And then after that, that's when we went to the hospital to get it x-rayed.

Participant 4 explained how both health systems and traditional medicine were utilized:

When they endured a lot of pain and they sought more into alternative medicine by using local remedies rather than going to the hospital because, although they have a hospital, it was more for emergency care and not like the routine annual checkups.

Participant 2 described her preference for traditional medicine:

And if we don't have to see a doctor and take the medicine ourselves or do whatever…we'll do it. So with my dad, if he didn't have to go to the hospital, he really didn't have to. If he had to deal with the herb medicine or whatever, he would deal with that.

Participant 3 shared the same preference for traditional medicine:

When you're looking for some kind of remedy, you're willing to try anything and everything, but that's the only thing that I can recall when they go to the doctor. That’s how it is if there's anything in your body, spiritual.  Anything that's bones that obviously cannot be fixed, they send you to the doctor.

Participant 7 described an experience where her treatment was more spiritual:

So the suruhanu actually did was gave me some prayers and when I say prayers, it's not the Our Father. You didn't have things like that. It's a language that I couldn't even understand. And so it was very strange for me, but I think after a

> day or two, initially it's an early in the morning or late in the evening, he will come over and do his usual rituals. And most people won't believe that, but after a day or two that's the time I started feeling more active.

Participants had some negativity in their health care experiences. Several participants explained that it started with how the provider or the staff delivered the care.

Participants 1 and 5 shared their feelings of these negative experiences receiving healthcare. Participant 1 said, “I felt like my care was not met...and to be put enough on a halt, it kind of destroyed my whole outlook of our healthcare at that moment.” Participant 5 provided an explanation of how she received such experience and said, “You know we are locals. We don't like honesty and you're too blunt. Need to word it and make it nicer.”

Participant 2 shared how she felt after a negative healthcare experience:

> And I can't necessarily talk to him a lot when I did start talking, yes, he’s blunt. He will go well, you need to lose weight. I said, I know that doctor, that's obvious. You don't need to tell me that. But, I go, this is what's happening with me.

Participant 11 shared her feelings for accessing healthcare after her loved one passed:

> I didn't trust the hospital for a long time and especially if they keep changing providers. I feel because what happened to my son was that they should have known. So I mean, I didn't know anything about that. So I guess from there, and I guess from what you hear from the hospital at the time, you don't want to go there. So I guess that's fear and just putting your trust into the doctor that are they

> really going to take care of you or are they going to prescribe you medicine and then you're going to die.

Several participants described experiences that may have some future effect on their health care access. Each participant’s experiences were different; however, it made some impact on how they see their future access to healthcare.

Participant 1 indicated, “I do care for my own wellbeing and I can't hold back from any information that the doctor may need in order for me to get the right treatment.”

Participant 2 expressed a challenge in trying to maintain a consistent provider:

> She pick and chooses and if you're not consistent in it all the time going there, then you're not necessarily going to be able to go back in because the load is heavy. It's so frustrating…So I'm asking myself, do I go back and reach out to Dr. W again, because I'm comfortable with her, but I don't even know where she's at now.

Participant 4 shared her positive experience accessing healthcare:

> It was pretty easy. I just called them up. I told them what was wrong. So I came in the next day and then they scheduled me to do the first one was the extreme to just to make sure that it wasn't COVID related or anything. I went in like within a week's time and then they scheduled me for the ultrasound also from scheduling time to actually getting it was also within that week period also, I think. So we didn't take long.

Participant 8 shared how she wants her healthcare access to be:

> Like I want to go see a provider, but I only want to see the provider once get a cure and get out. When I want, would I go to a clinic? I will want to go in and get checked and get whatever medication I need and then go.

Participant 9 shared her preference for her healthcare access:

> I, myself worry when I go to the clinic or the hospital, I don't know what I'm dealing with or something. I'm just a little paranoid because of all the health conditions that our people face every day… I want to know that you actually care.

Participant 10 also shared a similar preference:

> I would see my primary care physician unless he or she is not available then, and only then will I see somebody else. But they will make sure they will ask me if it's okay with me because I prefer that I see one doctor and who knows my history.

Participant 11 shared her many fears of accessing healthcare:

> I guess it's the fear of maybe them telling me I had a really bad diagnosis and then trying to balance that with work, I didn't want to be taking off from work that long or, or the fear of running out of paid leave and not getting paid. And how would it affect my family? How, how it would affect my job, I guess mostly, I think my family and my job. Would I still be able to perform the same way, knowing that I got this bad diagnosis.

## The Importance of Family in Healthcare Access

The importance of family was noticeable from the experiences shared by the participants. The participants provided their social and familial experiences during the interview. Some of the participants shared that they were also the caretakers for a family member.

Participant 1 described how he handles family needs and his health:

> I'm her caregiver. So I play a big role in her healthcare as well. I'm like the mediator between the nurses and the doctor. If I do need to see a doctor, when it comes to my health care, they know that it's important, so one will step in and, take after my caregiving time and shift and I will go see my doctor, and they're pretty understanding.

Participant 8 shared her similar priorities for family:

> I will be the one to take them, there were times where, because like right now my daddy doesn’t drive anymore. We don't allow him to drive. And my mom, a lot of times she's not feeling well….So they will call me, asked me if I could take them. So I will get out of work just to go and take them and get them checked.

Participant 11 shared how she could not care for her mom because of another priority:

> I took care of my mom for about two weeks. And then I got a new job. So that's where my dad had to go in and follow her. I was supposed to be the one who take care of her, but because I got hired and since I looked for a job for so long, she knew that I needed to work.

Several participants had thought about their familial responsibilities when accessing healthcare. Some of these participants stated family and social activities were significant and difficult to ignore.

Participants 6 described what it meant if you don’t attend family functions:

> Let me tell you, you’re marked as a rebel or black sheep of the family, because not only that your presence is needed, but the expectation for you to contribute and other things. So those are social impact, and we tend to forget our priorities in health.

Participant 1 shared how he puts his trust to God:

> It's not all about me anymore. It's about trying to help someone else. That was a way to get better. I have to be patient. Listen to what God’s plan has for me. I have to remind myself why I’m back in Saipan and the answer is I’m here for my mom. If I don’t take care of myself then how do I take care of her.

Participant 4 shared her family concerns:

> Another thing too, when it comes to family, I have children and I take my responsibilities and seriously also. So anytime I'm away from home, are my kids okay? And are they being fed? Are they doing their homework? Are they getting to school on time? Is the house secure and all of them because we can't take them with us to go do that. So it is stressful. If we have all of this on island, it will help with the stress level only because like I said, if I'm admitted in the hospital here,

> at least my kids can come and visit. Just being on the same island gives you that comfort that they're just at the next floor, the next village or, stuff like that.

Participant 8 shared how family activities made her cancel her healthcare:

> If it's just workdays or whatever that we can, of course, put aside and go and get checked but functions such as like getting the family and stuff, that's very important for us to make, even if it's not immediate family. I will not lie, sometimes. I mean, there was one time, I think that I cancelled my doctor's appointment because I needed to go and attend a family funeral, which is not immediate. It was a second cousin's funeral that you need to go on at 10, because that's just how we are. We go to our families' funerals.

Participant 11 shared her worries of having to leave the island for care:

> That was when I said, Oh my God, if I had low option, how do I get referral? That's what I thought about was my insurance. The very first thing that I thought about. And then I even went in to see if I could change it but you cannot until in the middle of the enrollment year, you gotta wait until open enrollment. So that scared me. What if I cannot go off island? Where would I get the money to pay for the doctor? Number two, could I go through medical referral? All of those things going in my head. What am I going to do?

Some participants expressed the need for family support when accessing healthcare and that when accessing the healthcare off-island, family support is even more critical.

Participant 4 shared when she had to bring her entire family to get healthcare off-island:

Back when we took my son, we have to take my other kids, because my husband didn't want me to go alone. And I'm glad he came along for support because when I found out my son had his hole, that just broke me down. But a lot of those things that happen to us when we're on abroad, when, when we're at home, we have our let's say our comfort and our support system here. I really think having the kind of support system we have here with our families, our extended families, our friends, it's one of the reasons why we're really resilient to things like this. Because just imagine during this call that we couldn't even go visit people at the hospital family members.

Participant 6 shared how the stress level went up for her mom because her family wasn't there for support:

It was hard for treatment. Being away from home and cut away basically from themselves and ourselves here in Saipan but more so you know, financially and also her health. And it actually contributed a lot of very unstable aspect in her recovery because of the stress level. Being away, not having the family support, and really the treatment was just long.

Participant 7 described the importance of having family support when accessing healthcare:

For example, my father and there's only a few of us here. Even though we can't be there all the time, we know we can run there at any given time. And that's the

> difference versus asking your siblings who would like to go and fly down to the Philippines and be there for that. I'd be like, I have work, I have my own family and there is an escort and things like that. You don't really want the negative side and have that guilty conscience. If surgery and things were done locally or those type of healthcare is accessible locally, then anyone that's close to that person, or my father can just stop by and give that support, whether it's a child or a brother, or a neighbor or friend.

## Research Question 3

The final research question explored the relationship between the culture of diversity and the dimensions of access. It explored how environmental control, biological variations, social organization, communication, space, and time orientation impact the dimensions of availability, accessibility, accommodation, affordability, and acceptability. I asked a series of questions (see Appendix A: IQ1-13).

### The Effects of Culture on Access to Healthcare

A couple of the participants described experiences, in which their culture affected the way they accessed health care services. They shared their own or their family member’s experiences.

Participant 1 shared how faith worked along with health:

> I think with my dad is whether he didn't want to know and he just left it for God to, to take care of it. When I think back, like with my brother, Dennis, he was very sickly when he was young. His nose will keep bleeding and they eventually gave him medicine and things like that. But my dad promised God that we would go to

> mass every day, early in the morning, every holiday of obligation. So he was very religious.

Participant 2, who is female, shared how the gender of her provider affected her access and said, “I want a female doctor. It doesn't matter what the situation is. No doctor got it, which is weird. I prefer a female doctor, but us growing up, it's ingrained with us growing up because that was just how.” Participant 12, on the other hand, shared how religion may have affected his access and said, “I did know I had health issues, but see, I'm just one of those stubborn individuals like my medical scare was probably God's way.”

A couple of the participants shared how cultural activities got in the way of them accessing health care. They explained how it delayed or prevented them from accessing care.

Participant 6 explained how important social and cultural activities were:

> We are a different type of people here in the state of mind. There's so much social interaction, then you feel pressured, you feel obligated and sometimes you forget about the right thing to do. We tend to forget. I mean, one thing that’s very common here is when there's death in the family, I mean, they'll cook, it's a Fiesta every night. And you know, we are obligated culturally and also family to make ourselves present on evening rosaries.

Participant 8 explained how her decision was made to cancel her provider appointment:

> If it's just workdays or whatever that can, of course we can put that aside and go and get checked, but functions such as like getting the family and stuff, that's very important for us to make, even if it's not immediate family. I will not lie sometimes. I mean, there was one time, I think that I cancelled my doctor's appointment because I needed to go and attend a family funeral, which is not immediate. It was a second cousin's funeral that you need to go on at 10, because that's just how we are. We go to our families' funerals.

### The Effects of Accommodation and Service

The participants also described their positive experiences when dealing with the accommodation given to them for health services.

Participant 1 shared how satisfying it was for him to have such accommodations:

> She's the one who makes appointments for me and we do the follow-up with blood works and whatnot. And then two weeks later, or a week later, I meet up with the doctor to follow up on my lab orders, health issues, such as cold or whatever emergency health issues that I see happening to me. I go directly to CHC clinic. If I don't need it at the weekly schedule, then I go directly to the ER.

Participant 3 shared what those accommodation meant to her:

> He would call me like, after work, like sometimes almost six o'clock. And I said, are you still working? And he said, this is where I catch up. So I had, I really have to commend him. Because it's not just a matter of seeing them and writing prescriptions. The care changed. So that's a big difference from before.

Some participants recognized the difference between a doctor from the U.S. mainland and a Chamorro doctor or another healthcare provider who understood the Chamorro culture.

Participants 4 and 9 shared their thoughts on this issue. Participant 4 said, “As a local doctor, I feel like she will understand. And she won't tell me not to take it only because she's part of the culture.” Participant 9 stated, “I think, culturally, they would understand how we work as a people, how we think as a people, how we function and live our lives as a people.”

Participant 2 expressed how important it is to be culturally sensitive:

> But it's just so much more for me as a local it's so much more comfortable to be able to go to our own doctor and know that, they have a better understanding of our culture. They know our demeanor and how much more sensitive in that essence, not to say that the approach, how they communicate with us about our health and what the issue is. They can be very blunt and brace, but very cold. Still be blunt, but still be warming and conscious of the person that's receiving the information.

Participant 10 shared similar thoughts:

> Their way of doing things in the mainland is totally different from how we feel here as locals. We need them to interact with us, and that is by no fault of their own. It's just how they've been doing business in the mainland. I think cultural considerations must be taken into account.

Participant 12 felt like some providers do understand but not all do:

> Whether from the ER and the clinic, I feel like they do understand. My thing is I would hope they have that cultural competency because you're here. Whether you're from here or not, but you should be able to like, better understand the culture and how a certain culture exists.

Some participants also described experiences when the provider lacked cultural sensitivity when they were delivering care.

Participant 9 tried to explain why this was significant and said, “We're very different. We're raised differently. We believe in different things, we have different practices and it'd be nice if they were culturally sensitive.”

Participant 2 wished how the providers she sees were already culturally sensitive:

> I’m like, man, I’m telling you how I feel. And you're going to degrade me whether it was not intentional, or what, it's just the delivery of how they are and not being sensitive. You can be sensitive and still be firm and say, look, I understand, but we need to do it this way, or this has to be done and you need to step up kind of deal. I just said, well, that's good to know. I know I'm going to be having this thing, but I guess I know that's life, but it was just the way and approach. He goes, well, we need to do your blood work. I said, yes, I'll do my blood work, but I'm delaying the blood work because I don't want to see him.

Participant 5 shared a similar desire:

> You know we are locals. We don't like honesty and you're too blunt. Need to word it and make it nicer. A doctor should start really be a little bit more culturally sensitive. And also listen to the person really.

Participant 10 shared that provider attitudes make a difference:

> I find, and it's also a big factor in patient care, I think, or at least for me, it is, is the interaction of the physician and the patient. I find sometimes although rarely some doctors are very abrasive and, and just come across as uncaring.

Several participants with negative interactions mentioned some positivity in their communication with their health care provider. When a provider was more caring or had diagnosed them correctly, that was considered a positive experience.

Participant 5 described how a provider made her feel, “She really encourages, she really tried to make things comfortable for us. Then after that I continued with her. And yes, I am very open to her. She's very open too.”

Participant 7 shared the need to have good relationships with providers:

> At the regular clinic that we go to, we would build a rapport. It’s been years that we've been going there, so there's some connection, right? You have that connection now. And so it's easy to speak, frankly, and get answers and share plans and how treatment should be and with the advice from the doctor.

Participant 8 shared how open she was to her providers:

> So there are times where I would ask them, can you take my blood? I want to know if my blood count is better because I'm also anemic. So they do that. Yeah. When I'm actually, they would do it also, but they're okay. So it's good. It's a good conversation.

Participant 12 described a positive experience as well:

> I just feel like they really take the time to listen and to understand what it is you're going through. I don't feel rushed. I feel like they really do take the time to really listen and just like really be open-minded and just provide the necessary care.

## Evidence of Trustworthiness

### Credibility

To ensure the credibility of my study, I used data triangulation. The process of data triangulation involves member checking (Patton, 2015). During the interviews, I compared and cross-checked the data, and I also asked questions for clarity, confirmation, and validation directly from the participants. After the interviews, I asked for their contact information just in case I needed to go back to them for clarification, confirmation, or validation. After transcribing the interviews, I sent the transcripts to the participants for their review, and I obtained their confirmation of the data and interpretation.

### Transferability

Transferability provides enough description of the study so that readers can determine if it is transferable to their situation and their research (Merriam & Tisdell, 2016). To increase this study's transferability, I provided a thick description of the interview process, including the setting and demographics. There was also the verbatim text from each of the participants which I included in the notes and I utilized for data analysis.

### Dependability

I reinforced the dependability procedure for this study using a voice recorder that captured each participant’s interview verbatim. I also utilized the recording option when using Zoom conferencing for the interview. Recordings ensured the study results were consistent with the data collected (Merriam & Tisdell, 2016). I made sure to ask permission from each participant before turning on the recorder. By recording each interview, I guaranteed the ability go back to the files for review.

There was also an audit trail of the research that starts from the recruitment process to the actual interview. I made sure to use my Walden University e-mail as a form of communication between the participant and myself to separate this communication from my other e-mails and so that it will be easier to recall. I followed my detailed steps for data collection and data storage. I transferred all the transcribed files to Nvivo (Version 13).

### Confirmability

For confirmability in this study, I inserted objective perspectives by using reflexivity. Reflexivity allowed me to self-reflect on what I have already gathered from the interviews (Merriam & Tisdell, 2016). I used the interview guide during the entire interview process. I included the verbatim transcriptions of each interview to provide contextual data and to ensure that I have detailed, rich data for my analysis. As I analyzed the data, I performed a conscious self-reflection to examine how I interacted with the study participants and strengthen this study's confirmability.

## Summary

The purpose of this qualitative study was to understand how the experiences and culture of the Chamorro people of Saipan affect their access and utilization of health services. This chapter provided detailed descriptions of my pilot study, the setting of the interviews, the participants' demographics, and the data collection and data analysis process that yielded the study’s themes. The participants were all selected using purposeful sampling techniques. The participants were provided the consent form via e-mail for them to read, and once they e-mailed back their consent to the researcher, data collection began.

I utilized the three research questions to organize the responses from the in-depth interviews. The first research questions looked at the lived experiences of the Chamorro people of Saipan and how the theory of the dimensions of health care access from Penchansky and Thomas (1981) affected their health care access and utilization. Most of the participants acknowledged that there were limited health services available on the island of Saipan, and that cost is a significant factor beyond just what they can access on the island. As a result, the participants’ experiences highlighted the dimensions of availability, accessibility, and affordability.

The second research question explored the lived experiences of the Chamorro people of Saipan to determine if environmental control, biological variations, social organization, communication, space, and time orientation, based on Spector’s (2002) theory, affected their health care access and utilization. With the shortage of services and providers on the island, the participants expressed their frustrations with this constant insufficiency by demanding better communication and better access. As a result, I found that communication, biological variations, and space were issues that the participants have dealt with when accessing services on the island.

The final research question explored how the cultural factors concerning access affect how the Chamorro people on Saipan accessed health care. The participants' responses showed some relationship between both theories of dimensions of access and cultural diversity in health and illness. Not achieving the availability, accessibility, affordability, accommodation, and acceptability of health care access highlighted the need to address environmental control, biological variations, social organization, communication, space, and time orientation in healthcare access for the Chamorro people on Saipan. Nearly all participants brought up issues relating to these in their interviews.

In the final section of this chapter, I discussed the methods of providing evidence of quality and trustworthiness, which made the study credible, transferable, dependable, and confirmable. The first was the process of credibility, in which I utilized data triangulation that validates the data I collected. The second process was transferability, in which I provided a thick description of the interview process and added verbatim text from the interviews. The third was the process of dependability, in which I utilized audio recordings for my interview. Lastly, I ensured the process of confirmability by using self-reflection and rich data descriptions from verbatim transcription.

In the next chapter, I discuss the interpretation of my findings and the study's limitations in-depth. I also describe recommendations for further research and the potential implications for social change. I conclude with my experiences and lessons from conducting this study.

# Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to understand how the experiences and culture of the Chamorro people of Saipan affected their access and utilization of health services. The literature review revealed that there were limited studies on the target population. The interviews conducted were focused on how the Chamorro people experienced and felt about the services within their health system. Understanding this phenomenon among the Chamorro people could help health administrators develop strategies to improve access to this specific population and eventually improve the Chamorro people's health outcomes.

The nature of the research was qualitative, aiming to identify patterns and processes and provide meaning and relevance to the study (Creswell, 2014). Qualitative research was appropriate to understand the experience of participants or someone close to them and how those affect access and utilization of health services (Morse, 2004). I used a phenomenological heuristic inquiry. According to Moustakas (2001), this method allows the researcher to look at lived experiences to get a clearer picture of their experiences over time and how these experiences affect the way they behave.

The following research questions provided the framework of my study:

1. What are the lived experiences of the Chamorro people of Saipan with availability, accessibility, accommodation, affordability, and acceptability of health care services on the island?
2. What are the lived experiences of the Chamorro people of Saipan with the environmental control, biological variations, social organization,

communication, space, and time orientation of the health care services in Saipan?

3. How do the cultural factors of environmental control, biological variations, social organization, communication, space, and time orientation impact the lived experiences of the Chamorro people of Saipan with availability, accessibility, accommodation, affordability, and acceptability of health care services on the island?

According to Creswell (2014), the research sample size should be consistent with the researcher's method and where the point of saturation or consistency is reachable. To address the research questions, I conducted 12 interviews to reach the saturation point. I heard from the participants how they accessed health care services, and I was also able to capture what came to mind before, when, and after they accessed these services. I transcribed the interviews and used NVivo data analysis software (Version 13) to manage the data and conduct the analyses. I used a two-cycle coding process in which various themes emerged.

The key finding for the first research question was that there was a challenge of accessibility and availability due to a health professional and services shortage on the island. The second research question's key findings were that historical, current, and future access are significant factors and that family is vital in health access. Lastly, the third research question's key findings were that there were effects of culture, accommodation, and service on healthcare access for this population.

In this chapter, I summarize and interpret the findings identified in the interviews. I describe the relationship between this study's two theoretical frameworks and key findings. I also discuss the study's limitations, list the recommendations for further research, articulate implications for social change, and provide a conclusion that captures the study's critical principle.

## Interpretation of the Findings

### Demographics

This study was about the Chamorro people and how they accessed health care on the island of Saipan. The participants were Chamorro individuals who were 18 years old and over and lived on Saipan. I did not include Chamorro individuals who lived on other islands in the Northern Mariana Islands, in any United States or territory, or in other countries. The village where the individual resides was not a necessary factor for this study. Neither was who their primary health care provider was.

Of the participants, there were nine women and three men. I attempted to get an equal number of male and female participants. However, because participating in this study was voluntary, I did not get equal male individuals to volunteer. Three of the 12 participants were unemployed but did have a source of income. All participants had health insurance, either from employment, retirement, or spouse’s health coverage eligibility.

The key finding for the first research question was that there was a challenge of accessibility and availability due to a health professional and services shortage on the island. The second research question's key findings were that historical, current, and future access are significant factors and that family is vital in health access. Lastly, the third research question's key findings were the effects of culture, accommodation, and service on healthcare access for this population.

## Research Question 1

### Health Professional and Services Shortage

Almost all participants described their experiences of having to deal with the shortage of providers, the lack of specialized providers, and the lack of Chamorro providers. The findings show that the only hospital on Saipan does not have sufficient services available on the island and, at minimum, provides moderate complexity laboratory services, some radiological services, respiratory services, and surgical services. Those who can find ways to access these services found a way to travel off-island, while others waited days, weeks, or months to have the government get them the means to do so. Still, the participants expressed the struggles of going off-island, such as taking time off from work, leaving their families behind, and wondering if they would face financial debt. Accessing specialized healthcare is not as simple as getting a referral from your primary care provider and going across the street to a specialty provider and still able to go home and be with family. Knowing that service is likely unavailable on the island can instill anxiety in facing these struggles, and the reaction was to avoid or delay access. Because of the tremendous cost and the need to have a family member accompany them, there was a reliance on the government or another entity to help ease such struggles. This finding was consistent with the literature that the unavailability of services was considered unreliable but acceptable (Feasley & Lawrence, 1998). This finding is also consistent with the literature that there is a reliance on another entity to support medical referral services (Abbas & Person, 2008).

When the participants accessed services on the island, the participants described health provider and service shortages' inconveniences. These inconveniences included long waits for appointments and results, rushed visits with the providers, and missing a doctor-patient relationship. Participants talked about how they would wait for weeks or even months before getting an appointment with a provider. When they finally got an appointment, some participants shared their experiences of waiting long to be seen. Some participants stated that once they faced the provider, their visit was quick and rushed because other patients were waiting. As a result, using the emergency room for primary care seemed justifiable, and a means to resolve pain and other health issues. This finding is consistent with the literature on the unwillingness to access health care (Rosario, 2010). The finding may also extend the knowledge that delaying care and having emergency visits may not only be due to the cost of care (Zelaya et al., 2017).

## Research Question 2

### Historical, Current, and Future Access to Healthcare Services

The participants described historical, current, and future experiences with health care access that affected the way they utilized health care services. The experiences consisted of positive and negative experiences over time. Some were their own experiences, whereas others were those they witnessed as it happened to their family members. Their reactions explained why they access care the way they currently do or why they avoided accessing health care at all.

The participants described their experiences that were significant enough to affect their access to care. The participants explained that their health was important enough to demand that their experience was worthwhile and expressed the need to have control. When a provider shows cultural insensitivity or was “rude,” as one participant described, the result was that the participant stopped showing up. With a shortage of providers, the outcome can worsen with regard to their health. This finding is consistent with the literature that the Chamorro people's historical experiences of being treated as primitives under colonial rule affect current behavior on health access (Pietrusewsky et al., 2014). The finding is also consistent with the literature that culture plays a role in health care utilization (Hawley & Morris, 2017).

## The Importance of Family in Health Access

The participants also described the importance of family in their lives. Some participants explained that they were the caretakers for a family member and that there is a need for family support when accessing care. The participants described how they had to include their families when making decisions about their health. Some expressed that health access and primary care visits cannot be a barrier to any family activities, such as helping prepare for a big party or attending a rosary, so they often opt to cancel their health visits. This finding is consistent with the literature that the Chamorro people have strong familial and religious beliefs that drive their culture and social and religious activities (Camacho, 2011).

## Research Question 3

### The Effects of Culture on Access to Healthcare

The historical experiences showed a pattern of practices that were common with some of the participants. Some participants shared their experiences with their parents using traditional medicine to treat ailments. Only when the participants' illnesses worsen or they have significant illnesses and injuries, their parents then sought a medical doctor or a provider found at the hospital. This finding is consistent with the literature that the Chamorro people wanted control of their health with traditional medicine (Torsch & Ma, 2000). Participants expressed their belief in traditional healing methods and used the hospital or any health provider only when necessary for their illnesses. While access to medicinal plants has become limited and rare, those who had used it had no hesitation in using it again if it was available for them. This finding is consistent that the Chamorro people utilized less medicinal and herb plants after the war (Willsey et al., 2019) but extends the knowledge that there is still interest in its use.

The participants described activities that affected their access to care. Participants stated the obligations of participating in familial and social activities to avoid getting shunned by their own family. As a result, they adhere to participation. This finding is consistent with the literature that Chamorro's social beliefs are of the highest priority and that social activities with extended families affect health utilization (De Frutos & De la Rosa, 2012).

## The Effects of Accommodation and Service

The participants also described their positive experiences when there was accommodation given when accessing services. Some participants realized the difference between a doctor from the U.S. mainland and a Chamorro doctor or healthcare provider who understood the Chamorro culture. The differences may result in the experiences of the provider lacking cultural sensitivity when they were delivering care. Participants with negative interactions mentioned some positivity in their relationships with their health care provider. Participants with positive interactions had an experience with a more caring provider who had diagnosed them correctly. This finding is consistent with the literature that when a patient whose culture is different from their medical provider, health care access may be affected (Ingram, 2012). This finding is also consistent with the literature from Hawley & Morris (2017) and Rosario (2010) that providers from another ethnicity played a role in health care utilization for some participants.

Participants shared that they wished they had a patient-provider relationship when accessing care. This experience makes it difficult for the participants to return to their provider for continued care. This finding is consistent with the literature that indigenous populations often require significant trust and a strong relationship with their medical provider to access health care (Denison, Varcoe, & Browne, 2014).

The participants described experiences when a health care worker or provider went out of their way to accommodate them. Even the simple follow-up calls to get them to access care were key to the participants' satisfaction. Because of this ease of convenience, some participants claimed no issues with access. This finding is consistent with the literature that experiences that create frustration and lack of motivation can affect access to care (Tsai et al., 2014).

## Limitations of the Study

I expected there would be limitations of the study in conducting the interviews. All participants in this study showed that they were comfortable being interviewed. All participants knew I was the head of the hospital, and the COVID-19 response put me in the forefront as also the territorial health official. I provided complete disclosure of my professional role, and I assured each participant that my role as a researcher was independent of my position at the hospital and health system. Despite my disclosure of this information, the participants proceeded with the interview.

The other possible limitation was my own bias as a fellow Chamorro living on the island of Saipan. Following Patton (2015), I exercised neutrality and ensured awareness of this personal bias. I assured the participants that their responses would be confidential and not identified in the study. After receiving their consent to proceed with the interview, I listened to the participants' answers to get their perspectives. I ensured to record and document verbatim quotations from the participants.

Another limitation was the limited representation of the participants. Of the 12 participants, nine were women and three were men. I attempted to get the same number of male participants as the number of female participants. However, because participating in this study was voluntary, I did not have equal male participants to volunteer. Also, I did not get sufficient evidence if the participants were experiencing any social determinants of health. During the interview, I gathered that three of the 12 participants were unemployed, but all three did have an income source. I also gathered that all participants had health insurance, either from employment, retirement, or spouse’s health coverage eligibility.

## Recommendations

This study can be considered preliminary research on how the Chamorro people on Saipan accesses and utilizes health care services. One recommendation for further research is to conduct similar research on a more specific group within that population. The particular group may be those that are affected by one or more social determinants of health. Social determinants of health are the barriers to healthy food, little or no health insurance coverage, no stable home, and lack of transportation to buy healthy food or go to health appointments (McElfish et al., 2019). Previous studies have connected the social determinants of health with health access. Addressing social inequities have been found to help improve health access (Le et al., 2017). Therefore, I recommend that future research obtain more data from similar participants and look into this social inequality.

## Implications for Positive Social Change

The potential impact of positive social change from the study results is to help health service professionals and administrators ensure a more appropriate health delivery system for the Chamorro people on Saipan. With a proper health delivery system, it can improve health access and utilization and, ultimately, this population's health. Having a better understanding of individuals' experiences affected by barriers to health care access and utilization can help guide and educate medical professionals about these barriers and improve overall care (Wheeler, Wylie, Villagomez, Bishop, & Raspa, 2019).

## Conclusions

According to Gilliland et al. (2019), access to health care and a primary health care provider affects the vulnerable populations' health. The Chamorro people on Saipan have high incidence of diseases, and it is essential to find out if their experiences and beliefs created barriers to healthcare access. This study looked at what drives the Chamorro people from accessing health care, using the theories of dimensions of access to health services described by Penchansky and Thomas (1981) and cultural diversity described by Spector (2002).

The in-depth interviews I conducted found several themes and barriers that had some effect on their access that can be removed by policymakers and health administrators. One critical finding was how the shortage of healthcare providers and services affected the Chamorro people’s access experiences. Family and financial situations have huge impacts when going off-island to access care, and the experiences of the participants gave them the awareness of this. Going to see your primary care provider should not mean subsequently leaving family behind and going into debt, but that is what some of the participants experienced or wanted to avoid. Therefore, I would like this research to start a conversation for leaders to consider reducing the shortage and making health care providers and services more available. The Chamorro people have a beautiful culture and are amiable people. Helping them with their health access is key to improving their health.

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# Appendix A: Interview Guide

**Restate the RQ, and define the phenomenon of interest.**

1. What are the lived experiences of the Chamorro people of Saipan with availability, accessibility, accommodation, affordability, and acceptability of health care services on the island?
2. What are the lived experiences of the Chamorro people of Saipan with the environmental control, biological variations, social organization, communication, space, and time orientation of the health care services in Saipan?
3. How do the cultural factors of environmental control, biological variations, social organization, communication, space, and time orientation impact the lived experiences of the Chamorro people of Saipan with availability, accessibility, accommodation, affordability, and acceptability of health care services on the island?

**Formulate an introduction to the interview. Start with an accessible, answerable question.**

Before we begin, are you comfortable with me conducting the interview in English or would you prefer to speak in Chamorro? Translation: Kao maolek ha fu’minu Enlis pat maolek’na fu’minu Chamorro?

Introduce yourself and explain the purpose of the interview.

Obtain signature on the Consent Form.

**• Begin the interview with a "warm-up" question—something that the participant can answer quickly and at some length (though not too long). Make sure the question pertains to the phenomenon of interest and will put you and the participant more at ease with one another to make the rest of the interview flow more smoothly.**

I hope all is going well and you're comfortable to begin this interview. Please do let me know if you don't want to answer the questions.

Let's begin with what you can tell me about your health.

I want to communicate to the participant that I am the individual that they can be comfortable to speak with.

## INTERVIEW QUESTIONS

1. Let's begin with providing a full description of how you accessed health services in the past year.
2. Please recall how you accessed health services when you were a child.
3. Please recall how your parents accessed health services.
4. Please describe a positive experience in dealing with your health.
5. Please describe a negative experience in dealing with your health.
6. Other than insurance and costs, please describe other barriers that prevent you from visiting your primary provider regularly.
7. Have you ever used traditional medicine?
8. Tell me about a time when family roles and responsibilities get in the way of accessing care?
9. Tell me about a time, if any, of when culture, family or religious beliefs prevented or delayed you from seeking care?
10. Do you feel you can freely speak to your doctor about your health?
11. Do you feel your doctor when speaking to you about your health issues respects your culture or religion?

12. After your clinic visit, do you feel you expressed yourself freely or did you feel you had to hide some information from him/her (culture, etc).
13. Did you have experience from the old days that stuck with you on how you received health services?

**Consider how you want to close the interview ("Is there anything else you'd like to share with me before we finish this interview?"). What can you say that will let the participant know they were "heard" and respected?**

Is there anything else you'd like to tell me about your health experience and/or perceptions of health on Saipan?

Thank you for your time and patience.

# Appendix B: Screening Procedures

***Via Telephone:***

Thank you for calling to find out more about my research study, or I am returning your call to provide more information about our research study.

My name is Esther Muna, and I am a doctoral student at Walden University, and I'm doing this research as part of my Ph.D.

The purpose of the research study is to understand the Chamorro people's experiences and behaviors towards health services and health and how it affects their access and utilization of health services. The findings of this study may explain the view of the Chamorro people of Saipan on the current health system and their health and their means of coping with it. This research will address a gap by providing an understanding of the Chamorro people's health services access and utilization as such information doesn't exist for this population today. The social change implications of the study will help health service professionals and administrators ensure a more appropriate health delivery system for this population and help them improve their health access and utilization and, ultimately, their health.

I will be interviewing people about their experience of health and health services. The interview will last approximately one hour.

Are you a Chamorro person? ___yes ____no

Are you 18 years old or older? ____yes _____no

(If they answered yes to both questions). Thank you, you meet the criteria to participate in the research.

Do you have any questions or concerns? Now that you have a basic understanding of the study, do you think you might be interested in participating? If No: Thank you very much for calling.[end call]

(If they answered no to one of the questions). You do not meet the criteria for the research study, but I appreciate your interest in the research. [end call].

***Via E-mail:***

Thank you for your e-mail and your interest to find out more about our research.

My name is Esther Muna, and I am a researcher at Walden University.

The purpose of the research study is to understand the Chamorro people's experiences and behaviors towards health services and health and how it affects their access and utilization of health services.

The findings of this study may explain the view of the Chamorro people of Saipan on the current health system and their health and their means of coping with it. This research will address a gap by providing an understanding of the Chamorro people's health services access and utilization as such information doesn't exist for this population today. The social change implications of the study will help health service professionals and administrators ensure a more appropriate health delivery system for this population and help them improve their health access and utilization and, ultimately, their health.

I will be interviewing people about their experience of health and health services. The interview will last approximately one hour. Before proceeding:

Are you a Chamorro person? ___yes ____no

Are you 18 years old or older? ____yes _____no

If you answered yes to both questions, you meet the criteria to participate in the research.

Do you have any questions or concerns? Now that you have a basic understanding of the study, do you think you might be interested in participating? If No: Thank you very much for responding to my e-mail.

(If they answered no to one of the questions). You do not meet the criteria for the research study, but I appreciate your interest in the research.