https://doi.org/10.20965/jdr.2022.p0372

Paper:

Migration in the Midst of a Pandemic: A Case Study of Pacific Islanders in Oregon

Scott Drinkall[*,†], **Jackie Leung**[**], **and Kapiolani Micky**[**]

[*]Schar School of Policy and Government, George Mason University
3351 Fairfax Drive Van Metre Hall, Arlington, Virginia 22201, USA
[†]Corresponding author, E-mail: scottdrinkall@gmail.com
[**]Micronesian Islander Community, Oregon, USA
[Received October 1, 2021; accepted January 21, 2022]

The Pacific Islander population in the United States continues to grow due to outmigration and a unique immigration arrangement. Under the Compacts of Free Association (COFA), citizens from three Remote Oceania countries can travel to the United States to live and work without restriction. Given the special status of COFA migrants, there is a growing interest among policymakers and researchers to better understand this population, which has often been overlooked. Unfortunately, the COVID-19 pandemic has recently spotlighted this community due to their exceedingly high rates of infection, hospitalization, and morbidity. This study examines how migration is experienced during a pandemic via a case study of first-generation Micronesians living in Oregon's Willamette Valley, one of the largest Micronesian communities in the United States. Interviews reveal how social determinants of health – such as economic stability, non-discrimination and equal treatment, access to healthcare, employment, and housing – may contribute to unequal health outcomes between Pacific Islander immigrants and other racial and ethnic populations. These determinants also contribute to human dignity. Using the emergent Migration with Dignity framework, this study assesses how the pandemic has challenged the six dimensions of dignity and disrupted the migration experience, including the push-pull factors for deciding to emigrate to and stay in the United States. Finally, the study assesses resources available for COFA citizens and avenues for improved support.

Keywords: migration with dignity, Pacific Islander, COVID-19, Micronesian, Oregon

1. Introduction

The purpose of this study is to examine the migration experience of Micronesians to the United States under the Compacts of Free Association (COFAs). This study utilizes a Migration with Dignity framework to assess how the COVID-19 pandemic has affected the quality of life of Micronesian COFA migrants in Oregon and to better understand social dimensions of pandemic response for COFA citizens. Socioeconomic and demographic factors are considered such as age, gender, and English language proficiency in COVID-19 response. Furthermore, the study takes an account of the resources available for COFA citizens in the state and explores ways to better support the community.

Given the exceptionally high COVID-19 infection and mortality rates among Pacific Islanders in the United States, the population as well as their associated health challenges have recently come to the fore. This research highlights the Micronesian population from the COFA nations and incorporates in-depth interviews to better understand the migration experience in the context of a pandemic.

1.1. Migration with Dignity Framework

Current approaches to migration are largely focused on creating national and international policies to better understand the surrounding issues such as the drivers for migration and integration of migrants into the host country. A crucial and typically lacking component, however, is a focus on the migrants themselves and their experiences in navigating the migration pathway.

In a statement to the United Nations General Assembly on September 26, 2014, Kiribati President Anote Tong described migration with dignity as an "investment in the education of our people and the up-skilling of our young population to equip them with educational qualifications and employable skills that would enable them to migrate with dignity to other countries voluntarily and in the worst case scenario, when our islands can no longer sustain human life" [1]. President Tong called for a refocusing of global attention to the socioeconomic and environmental challenges affecting large ocean states.

Migration will continue to be driven by acute or long-term trends such as climate change. Climate change has major impacts on lives, livelihoods, and rights. Concomitantly, there are legal systems and borders which serve to control and restrain movement. To address these challenges and refocus attention on the migrants themselves, the emerging Migration with Dignity framework is being developed and will include six key dimensions:

© Fuji Technology Press Ltd. Creative Commons CC BY-ND: This is an Open Access article distributed under the terms of the Creative Commons Attribution-NoDerivatives 4.0 International License (http://creativecommons.org/licenses/by-nd/4.0/)

1) freedom of movement; 2) right to be secure; 3) right of equality; 4) rights to a basic quality of life; 5) right to access services; 6) civil and political rights [2].

Along with the dignity framework, which is not fully finalized, a methodology is being developed for applying the framework in different scenarios. These include environmental and climate change, forced relocation of disaster-displaced communities, anti-immigration rhetoric and xenophobia, second generation migrants, and COVID-19.

2. Background

The Compacts of Free Association (COFAs) are treaties between the United States and the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and the Republic of Palau (ROP). These treaties offer benefits to both parties though may also be seen as reparation for the detonation of 67 nuclear weapons testing conducted by the United States in the Marshall Islands between 1946 and 1958. The Compacts allow for economic and military provisions for the three countries, including access to certain U.S. domestic programs such as military protection and the ability to serve in the U.S. armed forces.[1] In December 2020, Congress restored Medicaid eligibility for COFA citizens residing in the United States [3].

This arrangement allows eligible COFA citizens visa-free entry to "lawfully engage in occupations and establish residence as non-immigrants in the US and its territories" (Article 4, Section 141). Most COFA citizens may travel to, live, and work in the U.S., and likewise, U.S. citizens may travel without restriction to the three COFA countries. In exchange, the U.S. is allowed sole access to operate its armed forces within the large and strategically important Exclusive Economic Zones (EEZs) and operate military bases on land. These agreements are set to expire in 2023 for RMI and FSM and in 2024 for Palau – but may be renewed if Congress implements legislation and the COFA countries likewise agree to extend. Recent economic impacts of COVID-19 and climate change may play a role in renewal negotiations.

2.1. Population of Interest

The U.S. Government Accountability Office (GAO) conducted a study in 2020 of COFA migrants to the United States [4]. The report 1) estimated migrant populations and trends; 2) described financial costs associated with migration; and 3) assessed effects of the migration on governments, workforces, and societies. Utilizing U.S. Census Bureau data, GAO estimated more than 94,000 Compact migrants including their U.S.-born children and grandchildren residing in the United States and its territories. From the period 2005–2009 to 2013–2017 (and an enumeration of 2018), the population grew by 68% (from about 56,000 to 94,000). Historically, COFA migrants largely resided in the U.S. territories and Hawai'i; now, around 50% reside on the U.S. Mainland.

Table 1. COFA populations top 5 U.S. states.

State	*Estimated COFA population*	*% of state population*
Hawai'i	24,700	1.74
Washington	7,300	0.10
Arkansas[a]	5,900	0.20
Oregon	4,300	0.10
California	4,200	0.01

a. Other sources place the COFA population in Arkansas as high as 15,000.
Note, the U.S. territory of Guam estimated figure is 18,900.

The Pacific Islander population in the United States continues to grow, with notable concentrations of Micronesians living in the U.S. states of Hawai'i, Washington, Arkansas, Oregon, and California as well as the U.S. territories of Guam and the Northern Mariana Islands (**Table 1**).

2.2. COVID-19 Prevalence

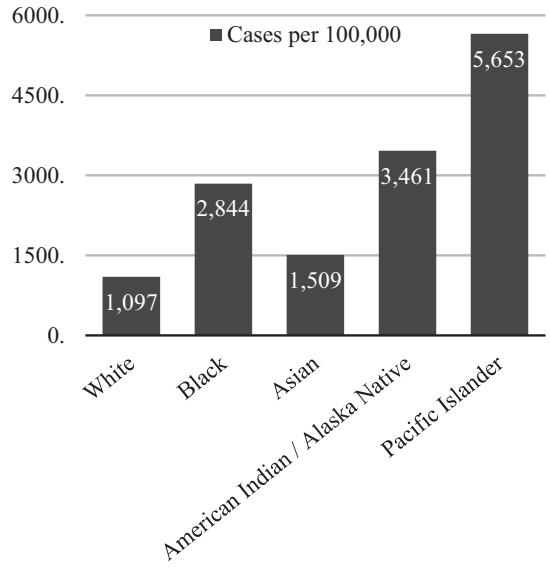
The United Nations Indigenous Peoples and Development Branch/Secretariat of the Permanent Forum on Indigenous Issues (IPDB/SPFII) warned that the COVID-19 pandemic would disproportionately affect Indigenous populations due to health inequities and other social determinants [5]. As a global anomaly, however, documented COVID-19 infection rates are low to non-existent across many Pacific Island countries. Among the nine countries[2] purported to have no COVID-19 cases as of December 2020, seven were Pacific Island states [6]. As of September 2021, the World Health Organization (WHO) listed 15 countries and territories presently without a confirmed case, 13 of which are Pacific and Atlantic islands (with North Korea and Turkmenistan constituting the remainder) [7].

Given the region's remoteness, limited social protections, and fragile health systems, aggressive travel restrictions and effective domestic responses at the onset of the pandemic were critical to avoid a severe health impact [8]. In the U.S., however, COVID-19 infection rates for Native Hawaiians and Pacific Islanders are shown to be higher compared to other racial and ethnic groups [9].

This case study focuses on Micronesian COFA migrants, specifically the Chuukese population from the FSM living in the U.S. state of Oregon. The state has a notable population of Islanders, particularly from Micronesia. While Micronesians are a unique group, most data lump the population as Pacific Islanders. As such, the

1. Domestic programs include disaster response under the Federal Emergency Management Agency (FEMA), services by the National Weather Service, the U.S. Postal Service, the Federal Aviation Administration (FAA), and the Federal Communications Commission (FCC), and Department of Education programs, among others.

2. The nine Pacific Island countries without a documented COVID-19 case at that time were Samoa, Kiribati, Federated States of Micronesia, Tonga, Palau, Tuvalu, and Nauru.



Source: Oregon Health Authority [15]

Fig. 1. Known COVID-19 cases in Oregon by race (December 2020).

data consist of information on Pacific Islanders. Pacific Islanders comprise approximately 0.10% of the state's population [10]; data from the Oregon Health Authority as of November 25, 2020 show that Pacific Islanders represented 1.3% of cases in the state [11]. Earlier in the pandemic, the rates were even more pronounced: In October, Pacific Islanders represented 1.8% of all confirmed and presumptive COVID-19 cases; 1.9% in September; 2.2% in August; and 3.1% in July 2020 [12]. At the peak, this proportion was 30 times that of the overall population proportion. While disparities exist among other minority populations across the United States [13], including Black and Latinx, Pacific Islanders are especially overrepresented.

At the end of November 2020, the hospitalization rate for Pacific Islanders in Oregon was 11.5% (the highest among all populations) and the fatality rate was 1.2% [14]. Data from the Oregon Health Authority's weekly report (December 9, 2020) [15] depicting known COVID-19 cases across races are shown in **Fig. 1**.

Other states have shown similarly high rates among other Islander communities. For instance, in November 2020, the Native Hawaiian/Pacific Islander population in California had the highest case rate among all races and ethnicities [16]. In Hawai'i, Pacific Islanders (not including Native Hawaiians) represented four percent of the population and 28% of COVID-19 cases – a five-fold greater risk than all other ethnicities and races [17].

3. Methodology

In the spring and summer of 2021, the non-profit Micronesian Islander Community (MIC) conducted 40 semi-structured interviews in the Portland-Salem, Oregon area with first-generation Micronesian COFA citizens. The Micronesian community is a guarded and quiet community. Due to the COVID-19 pandemic, it was challenging to contact community members as easily as it was prior to the pandemic.

The sample size is indicative of the small, yet growing community in Oregon. In line with quantitative research, interview results should be understood not to generalize the broader population but rather to better understand experiences of individuals and the nature of a particular problem [18].

Interviews were conducted in Chuukese or English, depending on the capability and comfort of the interviewer and interviewee. The interview questions were developed with attention to potential social, racial, ethnic, or cultural biases, and were reviewed by MIC prior to interviewing.

3.1. Participant Recruitment

Participants were required to be 18 years of age or older and first-generation Micronesians living in Oregon (and neighboring Vancouver, Washington).

Geographical location centered on Portland and Salem, the two larger population centers in the Willamette Valley and a known area home to Micronesians. Specifically, we focused on one jurisdiction of interest: those from the state of Chuuk, Federated States of Micronesia. This group is well represented in the Oregon Micronesian community as well as accessible by interviewers.

Individuals were selected via known associations within the community, church, and community health events, and "network sampling" in which interview participants were then asked for recommendations for others to participate.

4. Results

Among the 40 respondents, 60% were female and 40% male (none identified as another category). A range of ages was represented, with a plurality of respondents ages 35–44. Most were born in the FSM state of Chuuk; seven were from the FSM state of Pohnpei and one from the Marshall Islands. All held citizenship in COFA countries. Respondents were evenly split in their self-identified English ability among limited, conversational, and fluent. Around 78% of respondents had attained at least a high school diploma, around 43% had enrolled in college, and 15% had earned a college degree (35% of those who enrolled). Notably, 83% of respondents live in households with five or more people.

4.1. Emigration

Most respondents came directly from FSM before arriving in Oregon. Seven had lived in different U.S. states, including three from Hawai'i, and interestingly 10 previously lived in Guam – a clear stepping stone that corroborates the prior research study. Nearly all respondents had been living in Oregon for more than one

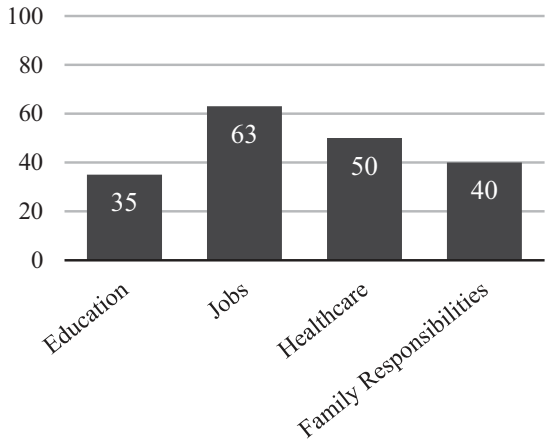


Fig. 2. Migration drivers (%).

year, with most residing one to three years (30%) or more than ten years (35%).

Survey participants were asked their reasons for emigrating to the United States. Prior research of Micronesian migration conducted in Oregon in 2019 [19] revealed similar drivers: education, jobs, healthcare, family responsibilities (**Fig. 2**). In a point of divergence, climate issues (sea level rise, increased storms, saltwater intrusion) were not mentioned as migration drivers for the 2021 sample population. Recognizing that migration drivers are often multifaceted and interconnected, respondents were able to select multiple reasons for emigrating.

Many respondents cited the need to access healthcare as a driver for migrating to Oregon. One referred directly to the COFA Premium Assistance Program that provides affordable health insurance for COFA citizens in Oregon by paying for health insurance premiums of eligible COFA citizens [20]. As another respondent explained, "I need to seek healthcare from out here since the islands have no medical services." While there are indeed four state hospitals and a private hospital in FSM [21], highly specialized medical care is typically performed outside the country.

Higher education and family responsibilities were also frequently cited as pull factors. One respondent reflected that despite qualifying for the Federal Pell Grant, tuition proved too great a struggle and work became the priority. While remaining in college proved difficult, one graduate named the university she attended and said, "It was important that I graduate." Another succinctly stated "I moved here to go to school. Then I went to work." Several women respondents noted they came to either accompany or join their husbands. One woman came to care for the children of her adult children who had already migrated. Another respondent explained "My brothers were already here, so it made sense for me to come out and join them too."

4.2. Livelihoods

As the survey population was and is largely employed in front-line jobs that were often among the first to be affected by state-wide shutdowns, many felt the brunt of the financial fallout. Job loss occurred in multiple ways. A number reported being temporarily laid off but have since returned to the workforce, particularly factory positions. In addition to experiencing business shutdowns, some lost significant time at work due to mandatory quarantines while others resigned from their positions to care for a family member or to ensure that they did not affect their family, some of whom had underlying conditions, or to assist their children who were attending school remotely. One respondent simply stated, "I was laid off from my work because I have COVID." For others, ongoing health issues impeded their ability to work: "I'm a stay-at-home dad due to my health situation, I have congestive heart failure."

For some, joblessness existed before the pandemic. As one respondent tactfully described being unemployed, "I worked until six years ago. I am not retired." For many, family provided a financial safety net; however, for some, the job loss of even one family member caused significant financial strain and in one case loss of housing. (Many reported a temporary inability to pay rent though did not indicate that they lost their housing.) Another exercised option was to move in with friends and family – a social safety net though one that causes additional strain.

Remittances are closely related to gainful employment. As one respondent stated, "I need a job to help my family here and also for family members who live back on the islands." However, many respondents indicated that they do not send remittances, some explaining that their family is mostly in the United States, that they were no longer able to send remittances, or that the amount had been reduced.

4.3. Health and Healthcare

Similar to the overall U.S. population, there was a range of responses to the pandemic, from suspicion to ambivalence to fear. Stress manifested itself through body aches, depression, fear, and loneliness. One respondent described her mindset: "scared, overwhelming, anxiety, you never know how you will get it and it's depressing. Especially when you have underlying diseases. Scared to lose your job and homes and love ones." The reality of the disease becomes acute once loved ones become infected. For one family, a parent and child were both infected. The parent explained, "I've never feel so afraid in my life when my son got COVID and he was having hard time I was so afraid and don't know what to do."

Quarantining due to exposure and the effects of general social isolation was felt by nearly all. Many experienced COVID exposure and infection. One respondent explained, "People in the house got sick and we all had to stay at home. It was hard because we had no money or food and could not pay rent." Another stated "My brother and my dad were quarantined. It was a lot of stress. It's

more like worry and scared to lose my dad and brother." Others expressed the feeling of loneliness: "I was lonely. I could not go to church and I really missed going."

Among the respondents, roughly a quarter reported having been infected and another quarter were unsure. Among those infected, the majority reported feeling shame to tell others. One respondent described the situation affecting not only those infected but also those perceived to have been infected: "There was a lot of shame and pointing fingers. [While] no one treated me differently.... I saw others who were treated differently because they had [COVID-19] or were thought to have it."

Social determinants of health – such as economic stability, non-discrimination and equal treatment, access to healthcare, employment, and housing – may contribute to unequal health outcomes between Pacific Islander immigrants and other racial and ethnic populations. These determinants also contribute to human dignity. Compounding effects of multiple diseases and certain environmental or social conditions – called syndemics [22] – may play a role in increasing likelihood of infection and morbidity.

4.4. Community Connection

The COFA Micronesian community in the United States is generally tight knit. This sense of community can be found in geographic areas with a large population of Islanders, such as the Marshallese enclave in Springdale, Arkansas, and in distributed populations, such as the relatively large Chuukese population in the Willamette Valley.

Prior to the pandemic, most respondents reported attending family gatherings, church events, birthdays, anniversaries, sporting events, funerals, and other islander activities such as FSM Day and COFA Legislative Day. During the pandemic and especially at the height, in-person gatherings were discontinued to ensure everyone's safety, and while virtual events replaced some in-person events, the impact was severe.

There is a striking contrast in the sense of community prior to the pandemic and during the pandemic (at the time the survey was administered). The great majority (88%) indicated they felt well or very well connected to the community prior to the pandemic; during the pandemic at the time of the interviewing, 49% reported feeling either not very well or not well connected. Prior to the pandemic, nobody reported feeling not very well connected; during the pandemic, nobody reported feeling very well connected. This is a key element for a variety of other health and wellbeing indicators. For many, church plays a crucial role in establishing community bonds, and their closure had a big impact on one's sense of community. One responded stated "It was hard because I could not go to church for a while. Now my church is open, and I am going back again."

The pandemic has highlighted the need for Pacific Islander partnerships at state, national, and international levels. At the state level, the non-profit Micronesian Islander Community (MIC) has bolstered their support of families and the community through COVID-19 support programs including providing facial masks, rental assistance, food boxes, and other extensive programming such as school supplies, resource sharing in person and virtually, and cultural sharing.

4.5. Mobility

Overall, most respondents indicated the pandemic has not affected their intention to either stay in the U.S. or to return to the Islands, with many intending to stay in the U.S. Some indicated concern about traveling and potentially infecting friends and family in the islands. Others were concerned about becoming infected after traveling home and not being able to receive adequate healthcare. Interestingly, travel has not been entirely interrupted, as participants shared traveling – sometimes far distances – for family events such as funerals and medical operations. Funerals are an especially important event for Micronesians and traditionally bring together many extended family members. During the pandemic, on occasion some were compelled to attend.

Even under the Compact and before the pandemic, travel bureaucracy greatly affects life decisions. Two respondents described a similar situation in which their ailing husbands wished to return to Micronesia before their passing but were unable to due to expired passports (one too-late renewal took five months). Another stated, "I am still here. I am waiting for the border to open so I can go home."

Recently, travel from the United States to RMI and FSM has opened, though entails COVID testing and quarantines in Hawai'i or Guam and post-flight in the Islands.[3] Travel to the outer islands in Micronesia is reported to present its own challenges.

5. Conclusions

5.1. Closing the Information and Needs Gap

Respondents were evenly split into two camps: 1) those who identified a need for resources that were considered unavailable and 2) those who identified a need for information to attain existing resources. The second camp recognized that resources existed but that they were not reaching the Islander community. Most notably, participants sought to know how to receive the COVID-19 vaccine and, earlier in the interviewing process, testing site locations.

Access to testing and, once available, COVID-19 vaccines has been an ongoing challenge for the Pacific Islander community in Oregon. Organizations such as MIC responded to this need in part by providing vaccination clinics for Micronesians, which were successful in increasing the number of Micronesians vaccinated.

Information is often accessed through social media sites such as Facebook, which can be useful, particularly

3. For the latest travel information for those residing in the U.S., visit respective embassy Web pages such as https://fm.usembassy.gov/covid-19-information/.

pages of established organizations. Those without Internet access or smart phones are at a disadvantage in securing timely information. Friends and family offer another source of information; however, it is important to note that reliance on social media, family, or friends introduces a risk of perpetuating misinformation, particularly about the vaccines.

5.2. Misconceptions and Language Barriers

While the pandemic has brought a greater awareness of the challenges Islanders face in the United States, there continues to be misconceptions about the population and their specific needs. For example, Pacific Islanders are often lumped together or thought to all come from Hawai'i. This leads some to believe that citizenship status and language for Pacific Islanders are the same.

Language access and accessibility for Micronesians is a crucial concern, particularly during a pandemic. Recognizing the concern, the Oregon Health Authority provides information on COVID-19, such as mental and emotional health, community resources, and vaccine information, in Chuukese and Kajin Mạjeļ (Marshallese), among other languages. The state health agency also provides a downloadable toolkit on its website with FAQs, talking points, and shareable graphics in both languages. Notably, the website explains that the vaccines "have been tested with thousands of people around the world. Black, Indigenous, Latino/a, Asian American, Pacific Islander, and communities of color have chosen to be part of these studies to make sure the vaccines are safe for our communities."[4] Developing informational materials such as voice recordings has proven difficult on account of securing qualified and committed interpreters through interpreting agencies, especially given the variety of dialects.

5.3. Spotlighting the Micronesian Islander Community

MIC was first established in 2010 as an informal gathering of two Micronesian communities. As the organization became more formalized, current Executive Director Jackie Leung reported that additional Micronesian communities joined before it formally became known as MIC. MIC has since built relationships with local and state agencies including county health departments, the Oregon Health Authority, Oregon Department of Human Services, the Oregon Healthcare Marketplace, and Oregon Department of Education, and has a national presence as well through collaborations with national leaders and organizations.

In early 2020, MIC formally separated from their fiscal sponsor, resulting in the formation of the organization in the midst of a global pandemic. Given limited funding and the great needs in the Pacific Islander community, MIC applied for funding for COVID-19 related support, and over the year was able to identify, apply, and be awarded grant funding from private foundations, organizations, and government entities. They were able to expand services and support families in other U.S. states and on the islands.

The pandemic has affected MIC's operations in multiple ways. On one hand, it expanded their funding opportunities and outreach services – though as the pandemic subsides these opportunities are dwindling. On the other hand, members of the community have experienced discrimination, particularly the elders and youth. MIC now operates with ten paid staff and is currently exploring options for purchasing space to provide a venue for community functions, a need recognized during the prior 2019 Oregon Micronesian study.

5.4. Migration with Dignity

Freedom of movement, security, equality, quality of life, access to services, and civil and political rights – six key dimensions of the emerging Migration with Dignity Framework – are woven throughout this study of the migration experience of Pacific Islanders in Oregon as experienced during a pandemic. These provide a useful framing for better understanding how dignity can be strengthened.

Interview data show a strong focus on the need for support, such as information on COVID-19 vaccine distribution, which is underway. Outreach efforts are also underway, such as a partnership between MIC and Kaiser Permanente to share information with the Islander community. Developing a central distribution system will allow for improved information exchange, particularly regarding healthcare. Additionally, information sources should be available in native languages and tailored to meet specific cultural needs. Some reported embarrassment to admit they had COVID-19 due to being stigmatized. To mitigate these concerns and others, healthcare facilities may refer patients to non-profit organizations that provide resources to meet the specific language and cultural needs.

Technology has played an important role in the pandemic response. As one respondent reported, "I talked to family on phone and video chat." Family members and non-profit organizations, including MIC and local churches, assisted with delivering food. Several respondents reported the importance of prayer as an effective way to cope. Community organizations have played a key role in providing rent, utility, and food assistance, passport notarization. For those who reported needed medical care, 72% were able to receive it.

Beginning in the fall of 2021, as restrictions have been loosened, many are concerned that the precautions taken by the community are insufficient or not being adhered to. Still, the vaccine has provided hope and resources are being allocated.

4. See the Safe Strong Oregon website for more information: https://www.safestrongoregon.org.

Acknowledgements

This study was supported by the JSPS KAKENHI (Grant Numbers 19KK0025 and 21H03711). The authors acknowledge the support of Prof. Ryo Fujikura, Hosei University. The authors would like to express their sincere appreciation to the Ocean Policy Research Institute of the Sasakawa Peace Foundation (OPRI-SPF) and the Nippon Foundation for their support of this study.

References:

[1] United Nations, "Statement by H.E. President Anote Tong, 69th UNGA, New York, September 26, 2014," https://www.un.org/en/ga/69/meetings/gadebate/pdf/KI_en.pdf [accessed December 10, 2021]

[2] S. N. McClain et al., "Migration with Dignity: A legal and policy framework," J. Disaster Res., Vol.17, No.3, pp. 292-300, 2022.

[3] Centers for Medicaid and Medicare Services, "Medicaid eligibility for Compact of Free Association (COFA) migrants," May 4, 2021, https://www.medicaid.gov/medicaid/eligibility/downloads/state-impl-short-term-workarounds-and-outreach-strategies.pdf [accessed September 5, 2021]

[4] U.S. Government Accountability Office, "Compacts of free association: Populations in U.S. areas have grown, with varying reported effects," June 2020, https://www.gao.gov/products/GAO-20-491 [accessed January 14, 2021]

[5] Department of Economic and Social Affairs, United Nations, "COVID-19 and Indigenous peoples," https://www.un.org/development/desa/indigenouspeoples/covid-19.html [accessed December 10, 2021]

[6] Johns Hopkins University Coronavirus Resource Center, https://coronavirus.jhu.edu/region [accessed December 10, 2021]

[7] World Health Organization, "COVID-19 dashboard," https://covid19.who.int [accessed December 10, 2021]

[8] R. B. Edwards, "Bubble in, bubble out: Lessons for the COVID-19 recovery and future crises from the Pacific," World Development, Vol.135, 2020.

[9] J. K. Kaholokula, R. A. Samoa, R. E. S. Miyamoto, N. Palafox, and S.-A. Daniels, "COVID-19 special column: COVID-19 hits Native Hawaiian and Pacific Islander communities the hardest," Hawaii J. of Health & Social Welfare, Vol.79, No.5, pp. 144-146, 2020.

[10] U.S. Census Bureau, "2019 population estimates, Oregon profile," https://www.census.gov/quickfacts/OR [accessed December 10, 2021]

[11] Oregon Health Authority, "Oregon's COVID-19 weekly update," November 25, 2020, https://www.oregon.gov/oha/covid19/Documents/DataReports/Weekly-Data-COVID-19-Report.pdf [accessed December 1, 2020]

[12] Oregon Health Authority, "COVID-19 News from Oregon Health Authority," November 28, 2020, https://www.oregon.gov/oha/erd/pages/covid-19-news.aspx [accessed December 1, 2020]

[13] J. T. Moore et al., "Disparities in incidence of COVID-19 among underrepresented racial/ethnic groups in counties identified as hotspots during June 5–18, 2020 – 22 states, February–June 2020," Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, Vol.69, pp. 1122-1126, doi: 10.15585/mmwr.mm6933e1, 2020.

[14] Oregon Health Authority, "Oregon's COVID-19 weekly update, November 25, 2020, https://www.oregon.gov/oha/PH/diseasesconditions/diiseasesaz/Emerging%20Respitory%20Infections/Weekly-COVID-19-Report.pdf [accessed December 1, 2020]

[15] Oregon Health Authority, "Oregon's COVID-19 weekly update," December 9, 2020, https://www.oregon.gov/oha/PH/diseasesconditions/diseasesaz/Emerging%20Respitory%20Infections/Weekly-COVID-19-Report.pdf [accessed December 12, 2020]

[16] California Department of Public Health, "COVID-19 race and ethnicity data," November 27, 2020. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Race-Ethnicity.aspx [accessed December 12, 2020]

[17] A. Hofschneider, "Hawaii Pacific Islanders are twice as likely to be hospitalized for COVID-19," Honolulu Civil Beat, November 20, 2020, https://www.civilbeat.org/2020/11/hawaii-pacific-islanders-are-twice-as-likely-to-be-hospitalized-for-covid-19 [accessed November 22, 2020]

[18] K. Malterud, V. D. Siersma, and A. D. Guassora. "Sample size in qualitative interview studies," Qual. Health Res., Vol.26, No.13, pp. 1753-760, doi: 10.1177/1049732315617444, 2016.

[19] S. Drinkall, J. Leung, C. Bruch, K. Micky, and S. Wells, "Migration with dignity: A case study on the livelihood transition of Micronesians to Portland and Salem, Oregon," J. Disaster Res., Vol.14, No.9, pp. 1267-1276, doi: 10.20965/jdr.2019.p1267, 2019.

[20] "The COFA Premium Assistance Program," https://healthcare.oregon.gov/marketplace/cofa/Pages/index.aspx [accessed December 10, 2021]

[21] U.S. Embassy in the Federated States of Micronesia, "U.S. embassy in Micronesia," https://fm.usembassy.gov [accessed December 10, 2021]

[22] M. Singer, N. Bulled, B. Ostrach, and E. Mendenhall, "Syndemics and the biosocial conception of health," The Lancet, Vol.389, No.10072, pp. 941-950, 2017.

Name:
Scott Drinkall

Affiliation:
Ph.D. Student, George Mason University

Address:
3351 Fairfax Drive Van Metre Hall, Arlington, Virginia 22201, USA

Brief Career:

2012- Legislative Analyst, Hawaii State House of Representatives
2015- Research Analyst, University Research Co., LLC
2018- Environmental Law Institute
2019- Nexight Group, LLC

Selected Publications:

• S. Drinkall, J. Leung, C. Bruch, K. Micky, and S. Wells, "Migration with dignity: A case study on the livelihood transition of Micronesians to Portland and Salem, Oregon," J. Disaster Res., Vol.14, No.9, pp. 1267-1276, doi: 10.20965/jdr.2019.p1267, 2019.

Academic Societies & Scientific Organizations:

• Association for Public Policy Analysis and Management (APPAM)
• American Association of Geographers (AAG)

Name:
Jackie Leung

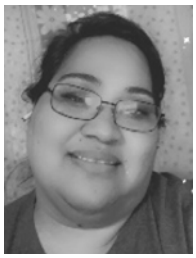
Affiliation:
Executive Director with the Micronesian Islander Community (MIC)

Address:
PO Box 18606, Salem, Oregon 97305, USA

Brief Career:
2018- Project Manager, Oregon COFA Program
2018- Ph.D. Student Studying Global Health, College of Public Health and Human Sciences, Oregon State University
2018- Salem City Councilor
2021- Assistant Professor, Linfield University

Selected Publications:
• C. K. Y. Nguyen-Truong, R. L. Fritz, J. Lee, C. Lau, C. Le, J. Kim, H. Leung, T. H. Nguyen, J. Leung, T. V. Le, A. M. Truong, J. Postma, R. Hoeksel, and C. Van Son, "Interactive CO-Learning for Research Engagement and Education (I-COREE) Curriculum to Build Capacity Between Community Partners and Academic Researchers," Asian/Pacific Island Nursing J., Vol.3, No.4, pp. 126-138, 2018.
• S. Drinkall, J. Leung, C. Bruch, K. Micky, and S. Wells, "Migration with dignity: A case study on the livelihood transition of Micronesians to Portland and Salem, Oregon," J. Disaster Res., Vol.14, No.9, pp. 1267-1276, doi: 10.20965/jdr.2019.p1267, 2019.

Academic Societies & Scientific Organizations:
• Oregon Commission on Asian and Pacific Islander Affairs American Public Health Association (APHA)
• Asian & Pacific Islander Caucus for Public Health
• Oregon Public Health Association (OPHA)
• National Association of Community Health Workers (NACHW)



Name:
Kapiolani Micky

Affiliation:
Micronesian Islander Community (MIC)

Address:
PO Box 18606, Salem, Oregon 97305, USA

Brief Career:
2017- Program Ambassador, COFA Premium Program in Oregon
2018- Program Coordinator, COFA Premium Program in Oregon
2018- Community Health Worker, Micronesian Islander Community

Selected Publications:
• S. Drinkall, J. Leung, C. Bruch, K. Micky, and S. Wells, "Migration with dignity: A case study on the livelihood transition of Micronesians to Portland and Salem, Oregon," J. Disaster Res., Vol.14, No.9, pp. 1267-1276, doi: 10.20965/jdr.2019.p1267, 2019.

Academic Societies & Scientific Organizations:
• National Association of Community Health Workers (NACHW)