



E OLA MAU

The Native Hawaiian Health Needs Study

Original Publication
ALU LIKE
Honolulu • December 1985

Reprinted by
PAPA OLA LŌKAHI
Honolulu • June 2016



Papa Ola Lōkahi
Nānā I Ka Pono Na Ma

Preface

It's been more than 30 years since the publication of E OLA MAU – The Native Hawaiian Health Needs Study and its recommendations across the board in the areas involving policy, research and data, programs and services, education, health care, and workforce development. This landmark study (report) provided guidance to local, state and federal agencies as to how each could contribute to the health and well-being of Native Hawaiians.

E Ola Mau was the catalyst that moved the passage of law, created innovative outreach and education, established providers of care, founded professional organizations, and developed a body of research – all components working together to enrich the overall Native Hawaiian health care community.

To prepare for the future, we look to the recommendations provided in the original study as benchmarks to which successes can be measured, achievements celebrated, gaps identified, emerging trends and innovations sought after, and to evaluate the process along the way. This seminal publication provides the foundation upon which to continue building a sustainable Native Hawaiian Health Care System for the lāhui.

For more copies of each of the task force reports, or to stay up-to-date with the current E Ola Mau efforts, please visit our website at www.papaolalokahi.org.

Table of Contents

COMPENDIUM OF EXECUTIVE SUMMARIES OF THE FOLLOWING FOUR TASK FORCES OF THE NATIVE HAWAIIAN HEALTH NEEDS STUDY

Preface.....	
I. Mental health.....	8
II. Medical.....	12
III. Nutrition/Dental.....	18
IV. Historical/Cultural.....	23

A PRELIMINARY PLAN FOR IMPROVING NATIVE HAWAIIAN HEALTH THROUGH HEALTH PROMOTION, DISEASE PREVENTION AND HEALTH PROTECTION

INTRODUCTION.....	30
I. NATIVE HAWAIIAN HEALTH PROFILE.....	34
A. Context for Health Planning	35
1. A Holistic Health Approach.....	35
2. The Cultural Equation.....	35
3. The Federal-State Responsibility: A Shared Commitment.....	36
B. Native Hawaiian Health Assessment Findings.....	38
1. Historical/Cultural Task Force.....	38
2. Mental Health Task Force.....	39
3. Medical Task Force.....	39
4. Nutritional/Dental Health Task Force.....	41

Table of Contents

II. RECOMMENDATIONS AND MODELS FOR NATIVE HAWAIIAN HEALTH PROMOTION, DISEASE PREVENTION, AND HEALTH PROTECTION.....	43
A. Committee Recommendations for Native Hawaiian Health.....	43
1. Historical/Cultural.....	44
2. Mental Health.....	46
3. Medical.....	49
4. Nutrition/Dental Health.....	56
B. Models for Native Hawaiian Health.....	60
1. Levels of Responsibility.....	60
2. Relationship to Federal Health Policy	61
3. In Keeping with Local Initiatives.....	61
III. STRATEGY FOR IMPROVED NATIVE HAWAIIAN HEALTH.....	66

E OLA MAU

THE NATIVE HAWAIIAN HEALTH NEEDS STUDY COMPENDIUM OF EXECUTIVE SUMMARIES

The Native Hawaiian Health Research Consortium

ALULIKE, INC.

Honolulu, Hawaii, December 1985

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Papa Ola Lōkahi

June 2016



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Preface

In FY1984, the United State Senate Appropriations Committee included a directive in the Supplemental Appropriations Bill for the U.S. Department of Health and Human Services (DHHS) to conduct a comprehensive health needs study of Native Hawaiians. On September 7, 1984, Senator Daniel K. Inouye sent a letter to Dr. Edward Brandt, Jr., Assistant Secretary for Health, requesting follow-up information on the health care needs study. Dr. Brandt referred the matter to Dr. Sheridan Weinstein of the Department of Health and Human Services (DHHS), Region IX.

Copies of the correspondence between Senator Inouye and Dr. Brandt were sent to interested parties in the community. ALU LIKE decided to pursue the health needs study further. ALU LIKE is a non-profit community organization assisting the Native Hawaiian community toward economic and social self-sufficiency. In November, ALU LIKE called together a group of University of Hawaii and community people with interests in the health needs of Native Hawaiians. The Hawaiian Health Research Consortium (HHRC) was formed as a result of this meeting. At a subsequent meeting, HHRC members decided to submit a health needs study concept paper to DHHS. The concept paper outlined the procedures for conducting the health needs study.

Dr. Sheridan Weinstein of DHHS-Region IX acknowledged receipt of the concept paper, but deferred action until the results from another research report were submitted.

In June 1985, DHHS provided funds to the Waianae Coast Comprehensive Health Center (WCCHC) to conduct the health needs study. WCCHC was selected as the prime contractor because the Center had existing ties with DHHS and an established system to disburse the funds. WCCHC then subcontracted the study to ALU LIKE for the overall administration of the project.

The contract called for a comprehensive review of existing health data on Native Hawaiians. The entire project was to be completed within a six-month time period. In order to accomplish the study within this short time-frame, the HHRC decided to organize the project around five task forces. Each task force would be responsible for health data within its assigned area. The five task forces included 1) Mental Health Task Force, 2) Medical Task Force, 3) Nutrition/Dental Task Force, 4) Historical/Cultural Task Force, and 5) Strategic Health Plan Task Force.

The short notice as well as the short time available to conduct this study created some limitations. The limited time prevented a thorough and comprehensive analysis of the health data and necessitated narrowing the scope of the study. The time constraint required task force members to commit a substantial portion of their time to the completion of the study, within approximately five months, and many individuals who were interested in working to the task forces could not do so because of prior commitments.

A second limitation is the relatively few number of health professionals who are Native Hawaiian. The lack of Native Hawaiians in the field prevented the HHRC from gaining more representation of Native Hawaiian perspectives on the various aspects of health and health care. This limitation is addressed in the Recommendations sections of the various Task Force Reports.

A third limitation involves the different definitions of “Hawaiian” used in various research studies. The United States Census uses a self-report definition of ethnicity. The Census asked people to select the ethnic group which best described them. The Hawaii Health Surveillance Survey uses a parentage definition - if one or more parents are Hawaiian or Part-Hawaiian, then the individual is classified as Hawaiian or Part-Hawaiian. The U.S. Census estimated that the Hawaiian population in 1980 was 118,251. The Health Surveillance Survey estimated the Hawaiian population at 175,909, a difference of over 50,000 people.

In this report, the term “Native Hawaiian” is defined as “any individual, any of whose ancestors were natives of the area which consists of the Hawaiian Islands prior to 1778.” This is the definition contained in the 1975 Title VIII Native American Programs Act declaring that Native Hawaiians are Native Americans eligible for special funds to provide services” to promote the goal of economic and social self-sufficiency.” Thus, this definition is an inclusive definition comprising groups of people who have been categorized as “Part-Hawaiian” or “Hawaiian.” When other research studies reviewed in this report deviate from this definition, this deviation will be noted.

Purpose

The purpose of this report is to present the findings and recommendations from a study of the mental health needs of Native Hawaiians residing in the State of Hawaii. The study was conducted by an eight-member task force working under the auspices of ALU LIKE, INC., a Native Hawaiian community action organization. Task force members included a spectrum of service providers and researchers familiar with Native Hawaiian mental health problems. Four members of the task force were Native Hawaiians. The study was conducted over a three-month period from July 15, 1985 to October 15, 1985.

The specific purposes of the study were: (1) to identify existing data bases and reports which addressed the topic of Native Hawaiian mental health, especially those which discussed rates of psychiatric disorders, exposure to psychiatric risks, and service utilization patterns; (2) to assess the validity and reliability of these reports; (3) to collect and generate needed supplemental data; (4) to prepare a culturally relevant context; (5) to prepare an extensive bibliography of relevant English language and Hawaiian language mental health materials; (6) to prepare supplemental materials including glossaries, personal statements, and literary quotations; and (7) to prepare conclusions and recommendations.

Conceptual Orientation

The present report identifies and evaluates available psychiatric and psychosocial research on Native Hawaiian mental health, including current records of psychiatric diagnostic rates, stress profiles, and service utilization patterns; however, discussions of this material were conducted with an explicit awareness of the cultural biases and limitations of the existing research and an awareness of the necessity of recognizing and being responsive to traditional Hawaiian conceptions of health and illness. The report asserts that these conceptions, rather than impose Western conceptions, should provide the basis for assessing Native Hawaiian mental health needs, since it is precisely the imposition of Western values and life styles that has been responsible for much of the cultural dislocation and disintegration leading to the current crises in Native Hawaiian mental health.

The present report asserts that Native Hawaiian mental health needs are a function of a complex pattern of pernicious economic, political, educational, and social circumstances which have deprived the Native Hawaiian of those psychosocial foundations which are necessary for promoting and maintaining a good mental health including: (1) a positive sense of ethnic identity; (2) a positive self-concept and sense of self worth; (3) a culturally consistent set of values and beliefs which are at least partially continuous with historical tradition; (4) a respect for one's ancestry and heritage; (5) a sense of political and economic empowerment; (6) a social formation which supports these characteristics; (7) a health system which provides accessible and acceptable services; and (8) an opportunity to establish and maintain a strong attachment to the 'aina (land).

In contrast to Western concepts of mental health which frequently separate psychological and somatic functioning, traditional Hawaiian conceptions emphasize the unity of body, mind, and spirit. The harmony of these dimensions emerges from a sense of psychic relationship with the land, the sea, and the spiritual world. The present study found that for many Native Hawaiians, the detachment from traditional beliefs and life styles based on harmonious relationships with nature and the spiritual world has created a felt sense of marginality, helplessness, and alienation. Thus, the present report emphasizes the importance of promoting traditional beliefs and life styles as alternatives to Western ways.

The task force recognizes that although there are many benefits to be derived from increased westernization for Native Hawaiians, there are also many risks, especially if the process of acculturation and assimilation is not buffered by the promotion of Hawaiian culture. Without the latter, there are no roots for socialization and social control, there is no frame of reference to guide morality and relationships, there is no felt sense of continuity with the past and no sense of community. The outcomes of this condition are mental illness, substance abuse, crime, delinquency, anomie, alienation, and a pervasive sense of anger and frustration. For many Native Hawaiians, there is a feeling that they are strangers in their own land, unwelcomed participants in society.

The task force also asserts that traditional Hawaiian values offer Western people an important alternative for finding personal meaning and growth in our contemporary world. Under the constant pressures to achieve personal power and material wealth, Western people also experience alienation and self devaluation and need a belief system and a way of life which can mediate their adjustment. Further, suppression and disdain for minority ways of life can only bring a false sense of superiority to the majority and deny them the opportunity for an honest appraisal of

their own worth. The oppressed and the oppressor are both losers in the pursuit of happiness and fulfillment. By devaluing minority ways of life, the majority populations are denied alternatives which may assist them in understanding and describing their world. Westernization is not modernization! Westernization is not progress! Westernization is simply a way of life whose final test, like all ways of life, is its ability to bring its followers peace, harmony, and personal meaning.

Organization of Report

The report consists of five chapters and six appendices. Chapter 1 discusses the background and methods. It also discusses the limitations of the study including the short time available for the completion of the report (three months), the many definitions of “Native Hawaiian,” the limited number of Native Hawaiian mental health professionals available for participation in the study, and the serious problems with the existing data bases. Chapter 2 discusses Western and Hawaiian conceptions of mental health and the extensive but unused literature on Hawaiian health concepts and practices.

Chapter 3 discusses the theoretical assumptions that guided the study and relevant socio-demographic data on Native Hawaiians. It also presents the results of analyses of existing data bases and resources. Chapter 4 examines service utilization patterns of Native Hawaiians and the lack of cultural accommodation within the mental health system. The chapter closes with a discussion of the many activist movements and activities of Native Hawaiian people, a fact which the task force believes signals a growing revitalization of Hawaiian culture. Chapter 5 presents the conclusions and the recommendations. The recommendations are divided into those which address program needs and research needs.

The appendices provide valuable supplementary material for the report including coverage of pertinent Hawaiian terms, personal statements of Native Hawaiians testifying to the quality of their life, a compendium of relevant mental health literature, quotes from Hawaiian literature designed to provide insights about the nature of the Native Hawaiian experience, and supplementary tables from statistical reports. The present report was intentionally structured to provide readers with a comprehensive understanding and appreciation of Native Hawaiian mental health needs by juxtaposing technical material with literary and subjective accounts of the Hawaiian experience. It was felt that this perspective would offer a deeper awareness of the Native Hawaiian condition.

The Native Hawaiian Population

An analysis of current social and demographic data on Native Hawaiians revealed that they constitute approximately 12% to 18% of the state’s population, depending upon the definition of “Hawaiian” which is used. Native Hawaiians are, on the average, younger than the state population and live in larger households and families. There are more female household heads among Native Hawaiians. In addition, Native Hawaiians have lower levels of educational attainment and lower average incomes. They are also less likely to be employed in executive, managerial, and professional positions.

The report summarizes the many different definitions of Native Hawaiian which are used by public and private agencies. The variations in these definitions point to a serious problem in identifying the Native Hawaiian population. The report also points out the fact that there are many different patterns of identification with Native Hawaiian life styles. Clearly, Native Hawaiians are not a uniform group. But it is also clear that the largest numbers of Native Hawaiians include those who are disenfranchised from participating in the dominant society and who are forced to live marginal existences caught between a devalued past and unacceptable present and future.

Methods

Within the brief amount of time available for the preparation of this report, the task force gathered all published and unpublished reports on Native Hawaiian mental health and also conducted brief surveys to supplement the findings. Most of the materials collected and analyzed were reports from state health agencies and from community action groups serving Native Hawaiians. Additional surveys of health officials and workers were conducted to provide data on cultural accommodation to Native Hawaiian life styles and sensitivity to Native Hawaiian problems.

A thorough evaluation of these materials revealed that they were characterized by many methodological problems which limited the validity of the findings. For example, the state health reports are often not standardized by age and they use diagnostic records which are notable for their unreliability. Community surveys are few in number and are not representative of the Native Hawaiian community. As a result, the statistical findings are, at best, a crude index of the Native Hawaiian mental health needs.

General Findings

The study indicated that, in comparison to statewide population estimates, Native Hawaiians have:

1. Higher proportions of social problems with family, people, and children, including higher proportions of assaultive acts and antisocial behavior;
2. Higher proportions of alcohol and narcotics use;
3. Higher proportions of school performance impairment;
4. Higher rates of suicide among young adult and elderly males;
5. Higher rates of child abuse and neglect (second only to Samoan populations);
6. Higher rates of residence in correctional institutions;
7. Higher rates of academic failure and poor school performance; and
8. Higher levels of stress as indexed by leading stress markers including poverty, educational level, single family households, dwelling density, and so forth.

The study also revealed that Native Hawaiians under-utilize mental health services because they are unacceptable as presently structured and delivered because they fail to accommodate Native Hawaiian values and life styles. There is little use of Hawaiian values and norms as treatment goals, there is little use of Hawaiian beliefs to describe problems, there is little awareness of Hawaiian cultural beliefs and practices regarding health, and there is little use of Hawaiian language terms in health care.

Virtually no training in Hawaiian culture is provided to public mental health workers. Further, there are few Native Hawaiian mental health professionals. There are some examples of successful Hawaiian-based mental health programs such as Hale Ola and the Opelu Project, but these are exceptions and even they do not receive the full financial support deserved and required to achieve their goals. The outcome of this indifference and this failure to accommodate Native Hawaiian ways of life is an absence of professional resources for mediating mental health problems and high personal, social, and economic costs to the community.

The study found that there is an extensive history of Hawaiian health beliefs and practices which could be used to provide culturally relevant mental health services. Practices such as ho'oponopono and lomi lomi could easily be included in existing service delivery programs. The former is a potent form of counseling which has proved to be a successful method of intervention throughout the Native Hawaiian community. But what is required in order to implement these health beliefs and practices is a major change in the ideologies and practices of the public mental health system.

Lastly, the study found that there is a growing sense of activism among Native Hawaiians which can be tapped to promote mental health. The report documents an extensive series of organizations and activities which reflect the Native Hawaiian struggle for empowerment, cultural pride, and competence. They demonstrate the potential vitality which is present in the Native Hawaiian - a vitality which could be used as the basis of promoting Native Hawaiian mental health and preventing illness and alienation.

Recommendations

The task force's recommendations are extensive. They include program recommendations and research recommendations. Because of their length, they will not be presented in toto in the present summary. The recommendation section should be read in its totality to fully appreciate the effort that is needed to cope with the mental health needs of Native Hawaiians. The program recommendations argue for:

1. The renewal and perpetuation of Hawaiian values to assist in the promotion of pride, self confidence, and personal power among Native Hawaiians.
2. The development of autonomous mental services which are community based and controlled by Native

Hawaiians and which are committed to Hawaiian culture, history, and language.

3. The development of educational training programs within the school system and within higher education institutions to facilitate an increase in the number of Native Hawaiian mental health professionals.
4. The implementation of cultural sensitivity and awareness programs under continuing education program auspices for mental health service providers. Certification of professional competence for dealing with Native Hawaiians should be required.
5. The development of political, economic, educational, and social programs to encourage empowerment.
6. The development of more programs to increase the availability of land to Native Hawaiians since it is from a relationship with the 'aina that all mental and spiritual health flows.

The research recommendations proposed by the task force were shaped by the mental health needs which the study revealed and by the following guidelines for conducting relevant research: (1) mental health researchers should be cognizant of and sensitive to Native Hawaiian culture, history, and language (2) research should be directed toward building community competence; and (3) research should involve Native Hawaiian people in the planning, conduct, and interpretation of investigations. The following research recommendations were proposed:

1. Conduct social epidemiological studies which focus on role expectations, performances, and adjustments rather than psychiatric epidemiological studies, which emphasize rates of severe mental disorders.
2. Conduct studies of natural support systems and networks.
3. Conduct studies of mental health service delivery options and preferences.
4. Conduct translation studies of Hawaiian language materials which involve health beliefs and practices.
5. Conduct evaluation studies of the effectiveness of existing educational programs including both public and private schools and institutions.
6. Conduct studies of ethnocultural identity and develop measures of alternative life styles and their impact on health practices and outcomes.

Purpose

The purpose of this report is to present a description of the current health needs of Native Hawaiians residing in the State of Hawaii, to identify factors which negatively affect Native Hawaiian use of health care services, and to suggest recommendations for adapting health care delivery to more effectively address the needs of this population.

The report is the result of a study conducted by task force members over a five-month period in 1985. The limited time and resources available to the task force prevented the systematic collection of new data and necessitated restricting the focus of the study to serious health problems having high prevalence among Native Hawaiians, specifically health problems associated with pregnancy and infant morbidity, diabetes, hypertension, heart disease and cancer. Furthermore, the field interviews were confined to health care programs on the Island of Oahu.

Within these limitations, the study undertook the following tasks: 1) to analyze existing data sets in order to compare the health status of Native Hawaiians with other ethnic groups in Hawaii; 2) to summarize data from existing agency reports regarding the relative prevalence of risk factors for disease among Native Hawaiians; 3) to summarize data from existing agency reports regarding the utilization of health services by Native Hawaiians; 4) to interview administrators and health workers in selected programs regarding apparent barriers to health services experienced by Native Hawaiians; 5) to describe the health needs of Native Hawaiians within a comprehensive conceptual framework; and 6) to develop recommendations based on the study for improving health services delivery to Native Hawaiians.

Conceptual Orientation

The Medical Task Force Report begins with a recognition that the health problems of Native Hawaiians reflect in large measure the social situation of contemporary Native Hawaiians. Native Hawaiians during the past 200 years have faced traumatic social changes. These changes have resulted in the loss of many traditions and have raised serious questions about the survival of Native Hawaiians as a distinctive people. Furthermore, the political and economic transformations of Hawaii, culminating with statehood and a modern commercial and service economy, have had the consequences of the loss of control over land and the loss of political power. Native Hawaiians currently are socioeconomically disadvantaged compared with the ethnic groups who have entered the Islands during the past 200 years. The combination of disculturation and low socioeconomic status is reflected in high rates of many social problems, a life expectancy about 6 years lower than the state average, and a high prevalence of many health problems in the contemporary Native Hawaiian population.

There is a tendency today to blame low status groups who experience health problems on improper behavior, and to approach improving health through efforts at controlling “undesirable” behavior, such as overweight, drinking, and smoking. There can be no question about the fact that these behaviors underlie health problems. However, many of these behaviors are themselves the product of stressful social conditions and a lack of resources with which to pursue alternative satisfactions in society. Rather than blaming the victim, the pursuit of better health necessitates social changes which would improve the life situation of the Native Hawaiian. In this sense, any steps taken to empower this group, to increase the level of self-efficacy, and to improve their economic situation, must be regarded as important to the promotion of health.

Nevertheless, while the Medical Task Force recognizes the above as an essential orientation, addressing the present health problems of Native Hawaiians cannot wait for more general socioeconomic change. Therefore, the report focuses more narrowly on describing the nature of Native Hawaiian health problems and on recommending immediate and direct strategies for reducing health problems through altering the delivery of health services. The report acknowledges, however, that there will be only limited success so long as Native Hawaiians continue to experience the current social and cultural deprivations.

The report does not approach the assessment of health needs as simply producing a list of health problems or statistical distributions of diseases. Health care includes all those activities which preserve well-being and prevent disease, in addition to treatments aimed at curing or controlling illness. Consequently, the report approaches the task of assessing health needs within a framework of the delivery of a broad range of health services, including health education, health promotion, screening and referral, and medical treatment programs. Three criteria of health service delivery are defined and used throughout the report: 1) the availability of services refers to the allocation of resources into health programs and the distribution of health services in relation to Native Hawaiians; 2) the

accessibility of services refers to the costs to the client in using services, such as financial expense, travel time and distance, and conflict between hours of service and work schedules; and 3) the acceptability of services refers to level of satisfaction or dissatisfaction Native Hawaiians experience because of the compatibility of health care services with Hawaiian culture and interpersonal style.

Organization of the Report

The report is organized into eight chapters. Chapter 1 provides a general framework for analyzing the health needs of Native Hawaiians. The criteria of availability, accessibility and acceptability of health services are defined, and an overview of health delivery to the Native Hawaiian population is presented in terms of these criteria. Chapter 2 describes the data sources available for the study, the definitions of variables used in the analysis, the procedures used in analyzing the data, and the methodological limitations of the study. Chapter 3 presents an overview comparing Native Hawaiians with other ethnic groups in the state of Hawaii in regard to causes of death, acute illnesses, chronic illnesses, and levels of disability. Chapters 4 through 7 present a detailed examination of specific health problems among Native Hawaiians, including epidemiological data and health care utilization information. Chapter 4 focuses on fertility, vital indicators and pregnancy outcomes. Chapter 5 focuses on diabetes. Chapter 6 focuses on hypertension and heart disease. Chapter 7 focuses on cancer. Finally, Chapter 8 provides a general summary of the findings and offers recommendations.

Summary of the Findings

In general, Native Hawaiians experience a lower life expectancy than other ethnic groups in Hawaii. This higher mortality is due both to a higher rate of accidental deaths as well as a greater risk of significant illnesses. Infant mortality rates of Native Hawaiians are higher than other groups, as are congenital abnormalities and underweight infants. Native Hawaiians, furthermore, suffer disproportionately from the most significant chronic diseases which underlie disability and mortality in later life, such as diabetes, heart disease, hypertension, and cancer. Native Hawaiians have higher cancer rates than other groups for cancers of the stomach, lung, and female breast and cervix. Furthermore, Native Hawaiians have a poorer survival rate from cancer compared with persons from other ethnic groups diagnosed at the same stage of disease. Based on age-standardized rates, the report concludes that Hawaiians have the greatest risk of diabetes, heart disease, and some forms of cancer, while Part-Hawaiians are somewhat more likely to suffer from hypertension. The evidence suggests that Native Hawaiians, furthermore, experience heart disease and hypertension at earlier ages than other groups, having higher rates even in the young adult population.

Evidence suggests that Native Hawaiians rank high on risk factors for many diseases. Native Hawaiians have higher rates of teen pregnancy and illegitimate births than other groups. Furthermore, pregnant Native Hawaiian women rank highest in having late or no prenatal care, in smoking and alcohol consumption during pregnancy, in toxemia and urinary tract infections during pregnancy, and in complications of pregnancy among the over 35 age group.

Surveys of health awareness in regard to cancer show that Native Hawaiians are less knowledgeable about symptoms and risk factors for cancer. What evidence is available also suggests that Native Hawaiians engage in behaviors which are high risk for developing diabetes, heart disease, hypertension, and cancer. For these diseases, high fat and salt consumption in the diet, being overweight, smoking, and heavy alcohol consumption, and for some diseases, a lack of sufficient exercise, create a greater risk of developing the disease. In all of these respects, Native Hawaiians tend to be at higher risk than other ethnic groups in Hawaii.

Although systematic evidence about the utilization of health services is sparse, the limited evidence reviewed in this report also suggests that Native Hawaiians receive fewer health services. Native Hawaiians appear to participate less than other groups in health education, health promotion, and screening and referral programs, even when these programs have been intentionally made available to communities where a high proportion of Native Hawaiians live and are offered free of charge. Furthermore, Native Hawaiians are reported to enter medical treatment at the late stages of disease, only when self-care and traditional practices have not brought sufficient relief.

The major problem does not seem to be the lack of available health services resources, since nearly all areas of the state are now served by some form of health services. Therefore, the reasons for under-utilization probably rest on lack of accessibility due to financial barriers, and even more importantly, on the lack of acceptability of services to Native Hawaiians due to cultural differences. The principle recommendations of this report, therefore, are aimed at addressing the need to alter the manner in which health services are delivered.

Basic Principles Underlying the Recommendations

The recommendations of this report have been developed out of a set of basic principles regarding conditions which promote effective health service delivery and how changes can be introduced into a community. These principles are as follows:

1. The under-utilization of health education, health promotion, health screening, and medical treatment services by Native Hawaiians cannot be addressed if we begin with the premise that Native Hawaiians lack concern about their physical health. Rather, under-utilization is a problem in developing a suitable mode of health service delivery for this population.
2. Effective health services will be developed and implemented for the Native Hawaiian population if Native Hawaiians participate in their creation, serve on the boards which oversee their implementation, and be in the health care professions which deliver the services.
3. Native Hawaiians have a special status in the population of Hawaii as Native Americans. Many of the health problems of this population stem directly from the negative impact other groups have had on their physical, social and cultural life. Therefore, there is a rationale to specifically target this population for programs designed to address their needs. The U.S. Federal government as well as the Hawaii State government have special obligations to provide financial resources and programs to the Native Hawaiian community as Native Americans.
4. Health services will be culturally acceptable to Native Hawaiians to the extent that they are compatible with Hawaiian culture and interpersonal styles. Therefore, modes of service delivery need to be adapted in so far as possible to the cultural concerns of Native Hawaiians. The following are three important components of Hawaiian culture which have direct implications for health services:
 - a. **Spiritual values.** The traditional culture of Native Hawaiians emphasizes the spiritual unity of the individual with the environment and the spiritual significance of events such as illness. Moreover, there is a rich tradition of health practices and rituals and respect for traditional healers among Native Hawaiians. Health services will be more effective if they respect these traditional values and concerns of Native Hawaiians.
 - b. **Minimization of risk.** The Hawaiian culture emphasizes the preservation of harmony. Individuals have a tendency to minimize the importance of experiences which set them apart from others or which threaten to disrupt the group. The “ain’t no big thing” coping strategy can result in efforts at normalizing symptoms of illness and delay in seeking health care. For this reason, a system of active outreach is needed rather than reliance upon individual initiative to seek out services, particularly for prevention and early care.
 - c. **Interpersonal Style.** Hawaiian culture has been described as centrally focused on affiliation, the development of close bonds between peers and the reliance upon personal networks in coping with problems. Native Hawaiians are uncomfortable with impersonal, bureaucratically organized services and with reliance upon expert authorities. Therefore, health services will be most effective if they utilize the natural social relationships existing among Native Hawaiians.
5. Native Hawaiians experience a disproportionate risk of many serious health problems, and the current mode of health service delivery is inadequately serving this population. In order to address the health needs of Native Hawaiians, a number of general structural changes and innovations are needed.

Recommendations

The following summarizes the general recommendations developed from the above principles:

Structural

1. That funds should be made available from the U.S. Public Health Service and other agencies of the Federal government in order to develop and implement needed changes in the health delivery system. These funds ought to be in the form of special contracts to accomplish specific purposes and in the form of seed money, with a gradual phase-out schedule, to modify or develop programs targeted for the Native Hawaiian population.

2. That the State of Hawaii, and specifically the branches of the Department of Health, reallocate resources to give priority to Native Hawaiian health problems.
3. That existing public as well as private health care organizations include qualified Native Hawaiians on their boards.
4. That an umbrella agency consisting of Native Hawaiians involved in health care be established for the purpose of monitoring Native Hawaiian health needs, planning health programs, and implementing the recommendations of this report.
5. That Native Hawaiian parity in the health professions be targeted through scholarship programs and academic support measures to provide for the education and training of Native Hawaiian youth for all levels of health professions.
6. That a system of Native Hawaiian community health workers be developed to provide outreach services, including health education, screening, referral, and follow-up care, on behalf of health programs serving Native Hawaiians. These community health workers should be Native Hawaiians who are personally familiar with the neighborhoods they serve and who therefore are able to serve as a cultural bridge between the community and health services.
7. That health education, screening and health promotion programs be provided through natural community groups having high Native Hawaiian membership. Providing services to individuals within the context of familiar social groups is more likely to be effective than individual oriented approaches.
8. That health-related organizations serving Native Hawaiian communities, especially in rural areas, develop programs which integrate Western and traditional Hawaiian approaches to health care and medical treatment.

Health Promotion and Education

9. That health promotion programs be developed to focus on life style changes within the framework of traditional Hawaiian culture to address the problems of alcohol abuse, tobacco and drug abuse, obesity, nutrition, and stress-management.
10. That health promotion programs and health screening be provided through natural social networks where individuals can experience social support from peers, such as in churches, civic clubs, canoe clubs and other community organizations having a high Native Hawaiian membership.
11. That state support be provided for targeting Native Hawaiians by agencies providing health education programs and screening and referral programs, especially in regard to cancer, diabetes, hypertension, and pre-natal and early infant care.
12. That more resources be provided to public schools to implement a comprehensive health education curriculum.
13. That family planning services be maintained to promote pregnancy planning consistent with the health needs of parents and children.
14. That the statewide perinatal health care system specifically focus on the Native Hawaiian need for education regarding the risk factors associated with congenital anomalies and low birth weight, and regarding proper infant care, breast feeding, and parenting behaviors.
15. That support be given to developing preventive and screening programs for cancers in Native Hawaiians.
16. That statewide screening programs for diabetes and hypertension be modified to target the Native Hawaiian population.

17. That screening programs for Native Hawaiians include systematic referral and follow-up, preferably using Native Hawaiian community health workers.

Access to Medical Care

18. That a fund be established by the State of Hawaii to provide medical care for medically indigent persons who do not qualify for Medicare or Medicaid programs.
19. That the state initiate measures to solve the malpractice insurance crisis, which impacts especially on the availability of medical care in rural areas where many Native Hawaiians reside.
20. That a review be undertaken of health programs, such as Queens Hospital and Lunalilo Home, which were established to provide care for Native Hawaiians, in order to determine whether or not these organizations are fulfilling their obligations.
21. That active outreach efforts be incorporated into every major health center in Honolulu and into clinics serving rural Native Hawaiian populations, using Native Hawaiian community health workers.

Medical Care

22. That a cultural training program be developed for physicians working in Hawaii regarding traditional Hawaiian beliefs, attitudes and practices of health care.
23. That health providers be educated about Hawaiian styles of seeking help and relating to others and that modes of service delivery be developed which are culturally compatible with Hawaiian culture.
24. That cooperation be fostered between traditional Hawaiian healers and physicians, perhaps using community health workers as a bridge, in order that the health needs of Hawaiians can be more effectively served by both.
25. That traditional Hawaiian remedies be incorporated into the care of Native Hawaiians whenever medically feasible.

Research Needs

26. That additional research be undertaken to investigate the etiological factors which account for higher disease rates among Native Hawaiians, such as higher rates of birth abnormalities, diabetes, hypertension, heart disease and cancer.
27. That research be undertaken to assess the prevalence and incidence of socio-environmental health problems among Native Hawaiians, including possibly greater exposure to pesticides, occupational hazards, social stress, and other noxious social and physical conditions.
28. That research be undertaken to focus on the level of health knowledge, attitudes towards health services, and cultural values which affect participating in health programs and using medical services.
29. That utilization data be systematically collected by all health programs and organizations in order to be able to determine the extent to which Native Hawaiians are receiving health services.
30. That evaluation studies be done of all health and related programs which target Native Hawaiians in order to ascertain their effectiveness.

31. That ongoing health surveillance of the Native Hawaiians be undertaken in order to determine trends in health status and current needs for health programs.

Conclusion

The report concludes that there are many critical health needs among Native Hawaiians which are not adequately addressed by the current health programs in Hawaii. In order to remedy this situation, recommendations are directed towards many different audiences, including the Federal government, agencies of the State government, health care providers, and the community of Native Hawaiians. New resources are required -- to believe otherwise is only wishful thinking. However, new resources in themselves are not the answer. The recommendations of this report focus on the need to change the mode of health delivery in order to improve its accessibility and its acceptability to Native Hawaiians. Change will only be possible with a sincere commitment to improve the well-being of Native Hawaiians and flexibility on the part of the many involved parties, including Native Hawaiians themselves.

Improving the health status of a population involves effort on many fronts, and not all the necessary changes can occur in a short time frame. Nevertheless, the Medical Task Force believes that now is the time to begin a process which requires the good will and cooperation of nearly every sector of our community.

I. Purpose

The purpose of this Task Force was to determine the nutritional and dental needs of Native Hawaiians. By assessing their needs, we would be more equipped to plan intervention programs suited to these needs. Thus, such programs may be effective in the solution of their nutritional and dental problems.

Three areas were selected as key indicators of the nutritional needs of Native Hawaiians. These areas were selected because of their importance and availability of data pertaining to the Native Hawaiians. The first area chosen was maternal and child health because of the vulnerability of this population to nutritional deficiencies which have lasting effects in later life. Second, was the relationship between diet and chronic diseases such as heart disease, diabetes, arthritis, gout and cancer. Third was dental problems because of its importance to physical health and the relationship between diet and dental health.

II. Methods

Two major sources of data were used for this study. The first was a review of literature on the nutritional and dental status of Native Hawaiians. The nutrition literature review was arranged according to the nutrition problems of the general population and various groups such as pregnant women, infants (0-1 year), preschool children (1-6 years), school-age children (7-16 years) and adults. The review of the nutritional status of the general population traced the development of the dietary practices of Native Hawaiians from ancient times to the modern age. The account on the dietary practices of modern Native Hawaiians started in 1954 up to the present.

The dental literature review also traced the development of dental health from ancient to modern times. The first methodical study showing a breakdown into different ethnic groups including the Native Hawaiian was done in 1940. Recent sources of data regarding utilization of dental services, dental insurance coverage and dental health manpower were obtained from reports by the Hawaii State Department of Health and interviews with dental health professionals working in the State of Hawaii.

The second source of data were based on the results of medical, dental and nutritional information obtained from records of patients who came to the Maternity and Infant Care Project (MIC) in Waimanalo, Oahu. Two time periods were selected for data collection: visits from 1970 to 1973 and 1980 to 1982 for pregnant women; 1972 to 1973 and 1981 to 1982 for infants; and 1972 to 1973 and 1982 for preschool children (1-5 years old). Two time periods were selected to provide a basis for comparison of data between the 1970s and 1980s. A total of 399 records were abstracted of which 201 were from pregnant women, 100 from infants and 98 from preschool children. Data collected from 1970 to 1973 and from 1980 to 1982 were pooled so that trends between the two decades could be noted.

The Waianae Coast Comprehensive Health Center (WCCHC) was the other site of data collection. The Nutrition Department of WCCHC has a caseload of 1,300 patients of which 1,200 are WIC participants. Of the 1,300 total population, approximately 900 are Native Hawaiians. A chart audit of Native Hawaiian patients who came to the WCCHC was conducted during the week of October 14 to 21, 1985. Recent risks status for entrance into the program were obtained from the certification form and tabulated.

Information from the review of literature and data collected from the MIC Project and WCCHC were summarized. Recommendations for planning nutrition and dental programs were delineated based on the assessment of needs and problems.

III. Major Findings

A. NUTRITION

1. General Population

Early reports have described the ancient Hawaiians as having fine physique and being generally in good health prior to their contact with foreign civilization. Their principal foods were fish, taro, sweet potato, breadfruit, yams, banana, greens, limu (seaweed), coconut, sugar cane and mountain apple. Their diet was simple and limited in variety

but adequate to promote growth and maintain good health.

As early as 1954, dietary surveys have shown a decline in the nutritional value of the diet of the Native Hawaiian. A survey conducted in 48 families in Oahu of which half were Native Hawaiians showed that 50% of them had diets that were deficient in calories, protein, phosphorous, iron and vitamin C; three-fourths had insufficient amounts of vitamin A and thiamine.

It has been noted in 1968 that the modern Native Hawaiian still use their traditional foods of taro and poi, but since they are no longer abundant and are expensive, they have resorted to readily available foods in the supermarkets. Their choices are foods high in energy, fats and sugars. Thus, we have seen an overall decline of the diet of the ancient Hawaiian from a simple, nutritious diet of fish, taro, breadfruit, yams and greens to one that is high in energy, fat and sugar. The change in dietary practices with urbanization and westernization seems to be a pattern which occurred in various countries of the Pacific Basin.

Two other dietary surveys have been conducted recently. However, one did not include ethnicity data and the other was done on a limited extent having been conducted only in young adults aged 18-26 years. Thus, since 1954, there have been no dietary survey data about Native Hawaiian families to determine any changes in dietary practices that may have occurred since that time.

2. Pregnant Women

Compared with other ethnic groups in Hawaii, the pregnant Native Hawaiian women have poor pregnancy outcomes. They have more fetal deaths, higher infant mortality rates and have a higher percentage of low birth weight infants. They also have a high number of teenage pregnancies. MIC data showed that compared with women in the 1970s, women in the 1980s had more miscarriages; their babies also had lower Apgar scores at 5 minutes (measurement of the overall condition of the neonate such as heart rate, respiration, muscle tone, reflexability and color at delivery). Pregnant Native Hawaiian women in the 1980s also had poor diets and more women drank alcohol. More women had anemia as evidenced by low hemoglobin values. However, women in the 1980s were less overweight, they had access to prenatal care early in their pregnancy and they utilized more of the government programs such as Medicaid and the Supplemental Food Program for Women, Infants and Children (WIC) as compared with women in the 1970s. Thus, there were some improvements in the overall health of pregnant Native Hawaiian women due to the use of these programs. However, they only had a minimal impact on the mother's dietary practices and her pregnancy outcome.

3. Infants

The prevalence of breast-feeding at hospital discharge in the Native Hawaiian mother had increased from 29% in 1969 to 81.5% in 1984. However, only 52% of these Native Hawaiian mothers were exclusively breast-feeding at hospital discharge and 22% stopped breast-feeding at 8 weeks. The mothers who were most likely to discontinue breast-feeding were mix feeders. The Hawaii Milk Bank survey of 1984 indicated that Native Hawaiian women were most likely to mix feed compared with mothers from other ethnic groups. The two reasons most commonly cited for discontinuance of breast-feeding was insufficient milk and sore nipples. Health professionals from the MIC Project stated that lack of support from the hospital and family contributed to the failure to breast-feed.

MIC data in the 1980s showed that bottle-feeding has declined. The introduction of semi-solid and solid foods has shifted from 2 months in the 1970s to 4 months in the 1980s. Infants in the 1980s as compared with those in the 1970s had generally good status as evidenced by greater lengths and weights and less anemia. Infants in the 1980s were also consuming more food compared to the infants in the 1970s and this may be due to the food supplied from the WIC Program. Overfeeding has led to more overweight babies in the 1980s than in the 1970s. Infants in the 1980s had lower head circumference (measure of brain growth) and lower Apgar scores. This may be related to the poor diet and intake of alcohol by their mothers during pregnancy.

4. Preschool Children

Both extremes of energy malnutrition (overweight and underweight) was found in the preschool population both in the 1970s and 1980s. Native Hawaiian preschool children were taller and heavier than their Oriental counterparts. Among the children attending the WIC Program in the 1980s, 10% were above the 95th percentile of weight for height indicating overweight. On the other hand, more than 10% of Native Hawaiian children at various months had low height/age and more than 10% had low weight/height at 12-23 months and 30-35 months indicating undernutrition.

MIC data indicated that Native Hawaiian preschool children in the 1980s weighed less at 1 to 3 years than children in the 1970s. However, by 4 years of age they were more overweight than children in the 1970s. More

children in the 1980s were shorter at 3 to 6 years than children in the 1970s. Children in the 1980s were better fed than children in the 1970s and fewer children have anemia. The shorter height at 3 to 6 years and lighter weights at 1 to 3 years of children in the 1980s may be due to the mother's poor diet during pregnancy. However, with the use of additional foods from the WIC Program they were able to catch up in weight by 3 to 5 years. This showed the beneficial effect of the WIC Program in improving the health of children.

5. School-age Children

Native Hawaiian school-age children were as tall as mainland United States children but were heavier than mainland and Oriental children in Hawaii. A dietary assessment of the intakes of school-age children in 1980 revealed that the Native Hawaiian elementary school children had the highest energy intake among all the other ethnic groups. They also had the greatest intake of high sugar and high fat foods. At the junior high level, they had the highest intake of sugar and second highest intake of fat and calories. At the senior level, they still ranked third highest among all others in caloric intake.

6. Adults

The Native Hawaiian adult was at greatest risk for cardiovascular disease, myocardial infarction, diabetes, hypertension, arthritis, gout and cancer of the breast, lung and stomach than adults of other ethnic groups in Hawaii. Two nutritional factors contributory to the incidence of heart disease in the Native Hawaiian were being overweight and a diet high in energy and saturated fat. Native Hawaiian adults were taller and heavier than their Oriental counterparts and this was evident from preschool years. Their diets were generally high in energy due to large intakes of food or on some occasions, alcohol. There was also a record of a sporadic or widely fluctuating caloric intake ranging from 1000 kcal for one day and 4000 kcal during weekends. A high percentage of calories from the diet were from fat and mostly from saturated fat.

A high fat diet has also been implicated in the incidence of prostate and breast cancers. Dietary intake studies at the Cancer Research Center of Hawaii showed that Native Hawaiians had the second highest intake of fat in the diet next to the Caucasians. Another dietary factor suspected to be a risk factor in cancer was the high concentration of mutagens in some Hawaiian foods such as dry/salted fish and kalua pig.

B. DENTAL

Prior to 1778, there was very little tooth decay in the young Native Hawaiians and it was virtually non-existent in the young child. By 1930, tooth decay was endemic in Hawaii and the majority of Native Hawaiian children had dental decay. In 1960, a survey revealed that the caries attack rate in Hawaii for the permanent teeth among children 6-14 years was one of the highest in the nation. Dental caries was identified as a serious public health problem and the most prevalent chronic disease affecting the people of Hawaii at that time. Native Hawaiian children had one of the highest DMF (decayed, missing and filled teeth) rates. Subsequent studies also showed that they have one of the highest periodontal disease rates and the poorest dental hygiene.

One of the factors attributed to the decline in dental health was a change in diet from a high starch, low refined sugar diet to a high sugar, low starch diet. Native Hawaiian children had the highest frequencies of consumption of caries-producing foods such as sweet beverages, dessert items, snacks and candy or gum. Other foods which were found to be associated with plaque formation were sweet rolls, sweet breads, manapua (Chinese dim sum or meat and vegetable wrapped in a wheat or rice flour casing) and poi. Poi, the traditional staple food of the Hawaiians, was shown to be positively associated with the number of teeth with heavy plaque accumulation.

Another factor responsible for the high caries rate in Hawaii was the negligible fluoride content of Hawaii's civilian water supply and the repeated defeats of proposals to fluoridate it. Efforts are underway to get legislation passed for fluoridation of water supply. There are various programs in the community designed to improve dental health either through education or treatment on an individual or statewide basis, but these have had only a very minimal impact on the reduction of dental problems.

IV. Recommendations

A. NUTRITION

1. Nutrition Education

There is a need to help the Native Hawaiians recognize the essentials of a good diet through nutrition education. Pregnant women need to be informed of the relationship between diet and intake of alcohol and other substances to pregnancy outcome. Children need to learn how to select a balanced diet at home and in school to prevent obesity, anemia and other nutritional problems. Nutrition education should be taught in day care centers and be part of the curriculum in elementary and high schools. Adults need to be shown the benefits of a sensible dietary guideline in the prevention of chronic diseases. These guidelines include eating a variety of foods, maintaining a desirable body weight, avoiding excessive fat, saturated fat, cholesterol, sugar and salt intake, eating foods with adequate starch and fiber, and limiting the consumption of alcohol.

2. Research

Several areas were identified in which data is lacking. These areas include the nutritional status of pregnant and lactating women, infants, preschool children and adults. No studies had been done to elucidate the relationship between the diet of a pregnant Native Hawaiian woman and her pregnancy outcome. There have been no dietary intake studies of Native Hawaiian lactating women to determine the relationship of their diet to the quality of her breast milk and her infant's nutritional status. Data on the dietary intakes of Native Hawaiian infants, preschool children and adults are outdated since they have been done in the 1970s. Thus, research needs to be done and fostered through support of research funding and facilities.

3. Nutrition Surveillance

State legislators, state and county agencies and private sectors should coordinate efforts to develop a good system of nutrition data collection, retrieval, dissemination and surveillance of the general population. State agencies should coordinate efforts to compile nutritional data according to ethnicity and use this as baseline information to monitor the nutritional status of the population and as basis for formulating nutrition policies.

4. Promotion of Breast-Feeding

Although breast-feeding has increased from 29% in 1969 to 81.5% in 1984, there remains a need to encourage women to breast-feed exclusively, where possible, and follow the 1990 Objectives for Hawaii which states that exclusive breast-feeding should be increased to 75% at hospital discharge and 65% at 8 weeks. Health professionals in the hospital and community needs to encourage women to breast-feed. Pregnant women need to be taught the advantages of breast-feeding and how to breast-feed before delivery. Establishment of support groups in the community to help new mothers to breast-feed successfully is also needed.

5. Continued Funding of Nutrition Programs

The beneficial effects of nutrition programs especially among vulnerable groups such as pregnant women, infants and children have been documented. These programs include the MIC Project, WIC, Headstart, School Lunch, Expanded Food and Nutrition Education Program (EFNEP), Nutrition Education and Training (NET) and others. There should be continued funding of these programs since they are presently being reduced under the current federal administration. These programs should also be maintained because the Native Hawaiian population have increased their use of these programs and in some instances such as the WIC Program, they were shown to be the greatest users of this program.

6. Provision and Promotion of Native Hawaiian Cultural Food Resources

Sources of Native Hawaiian foods such as fish, taro, sweet potato and yams have decreased due to urbanization. Legislation is needed to restore these food supplies by promoting economic feasibility for farming and restoration of fishing rights. The use of traditional foods should also be encouraged among the Native Hawaiians.

B. DENTAL

1. Fluoridation of Water Supply

Efforts should be enhanced to support the fluoridation of the civilian water supply. Incentives or assistance should be offered to owners of private water systems in fluoridating their water system. Alternative methods of fluoridation such as self-applied fluoride programs should be provided to all children until they have access to fluoridated water.

2. Dental Education

Educational programs addressing oral hygiene, routine preventive dental care for caries and periodontal disease control should be made available to all families. Children in public and private schools should be educated on dental health and hygiene using methods that are geared to the Native Hawaiian population.

3. Research and Early Dental Treatment

Public and private agencies should work together to do regular surveys of the dental status of Hawaii's population, especially of children. Immediate and appropriate treatment should be provided close to the survey site at no or low cost to those without dental insurance.

4. Dental Protection in Sports

There should be maximum protection against dental injuries for all youngsters involved in competitive sports such as basketball, soccer and hockey by providing them with appropriate mouth and head guards.

I. Purpose of Report

To provide historical and cultural context to E Ola Mau (Hawaiian Health Needs Study Report) with appropriate conclusions and recommendations.

II. Conclusions

A. Historical and cultural health data on ka po'e (Native Hawaiians) are not adequate. The reasons include lack of systematic attention to health indices for Native Hawaiians, varying definitions and ascertainties of "Hawaiian," and dramatic historical changes in, but irregular enumeration of, Native Hawaiian population bases.

B. Nevertheless, the available historical information reveals that for more than 1,500 years prior to 1778, there flourished a generally robust native po'e adapting well over the centuries to their island ecosystems in a cluster of mid-pacific islands later to be called Hawai'i. Cultural values and practices stemmed from basic concepts of lōkahi with a living, conscious and communicating cosmos; harmony with self—na'au (mind), kino (body), 'uhane (spirit), wailua (dream soul), and others--'ohana (family), kupuna (ancestors), 'aumākua (ancestral gods), and nature; observance of kapu (sacred law) and communication with the spiritual realm to maintain mana (special energy). These beliefs and practices were generally effective in promoting wellness and preventing and controlling illness.

C. Western impact, beginning in 1778, resulted in spiritual devastation and almost complete eradication of the Native Hawaiians. The main factors in this decimation were introduced infections, native hypersusceptibility and lack of immunity, and haole (white) economic, political, social, cultural and military control, with resulting Native Hawaiian despair and, for many, loss of will to live in a world that had become hostile and no longer meaningful.

D. The illegal overthrow of the Hawaiian kingdom by a haole oligarchy, aided by U.S. armed forces in 1893, and subsequent annexation by the U.S. in 1898, without consent of, or compensation to, ka po'e Hawai'i, continued the abuse and humiliation of Native Hawaiians with further loss of our culture, religion, language, lands, status and power. In spite of the rise in the Part-Hawaiian population our adverse health profile persisted as just one dimension of a conquered, indigenous people alienated from a non-indigenous government.

Most po'e Hawai'i have not adapted to the dominant haole economic, social, political and educational system, unlike many Asian immigrants. Yet, too many Native Hawaiians have embraced some harmful western ways, such as ingestion of excessive malnutrients (fat and sugar) and inadequate dietary fibre; tobacco, alcohol and drug dependence; lack of physical fitness; and malcoping with ko'iko'i (stress).

The current health care system has failed to address and improve the health status of ka po'e Hawai'i.

E. In spite of the grim health profile of our po'e, some traditional Hawaiian cultural strengths persist, and are even admired by some non-Hawaiians, e.g.,: reverence for nature, expressed as aloha 'aina (love of the land), communication with the spiritual realm, group affiliation over individual assertion, sensitivity to others' moods, avoidance of confrontation, minimization of risk ("ain't no big ting"); child-rearing; desire to continue a basic lifestyle close to the land and sea within an extended 'ohana; and pride of heritage, such as in revitalization of mele (song), hula (dance), other arts and crafts, lawai'a (fishing), mahi'ai (farming), and lapa'au (Hawaiian medicine).

F. Two main options appear available:

1. Continue to ignore Native Hawaiian health problems as has been usual in the past. Two subsets of po'e Hawai'i will emerge:
 - a. Native Hawaiians who will undergo further de-Hawaiianization and become assimilated as non-Native Hawaiians, even though they may occasionally be identified as Native Hawaiians. Most of the relatively

small number of affluent Native Hawaiians already belong to this class. By attaining personal achievement in and on haole terms, most have rejected traditional Hawaiian cultural group affiliation. Health problems and other social ills, as “Hawaiian,” cease to exist for them. This goal of assimilation was the official mission of the missionaries; was, and still may be, the goal of the Kamehameha Schools; and is still advocated by some Native Hawaiians and many non-Native Hawaiians for Native Hawaiians.

- b. Native Hawaiians who will continue as the landless, dispossessed, culturally-confused, sick, and thus, will persist as “the Native Hawaiian problem.”
2. Kāko’o (support) Native Hawaiians in furthering our spiritual and cultural identity, so that through our improved coping skills, self-esteem and support systems for political self-determination and economic self-sufficiency, we may regain our land base for pursuit of more meaningful lives and thus, improved well-being, including health.

G. We Native Hawaiians may recover and maintain our ethnic identity in two main ways:

1. Resistance to the dominant haole society, which may take two forms:
 - a. Passive resistance, while we quietly maintain aspects of our culture.
 - b. Active resistance, through confrontation and control, and thus, with loss of some of our traditional ways.
2. Biculturalism (Native Hawaiian and haole), which requires:
 - a. Tolerance, respect, understanding and kāko’o by non-Native Hawaiians.
 - b. By po’e Hawai’i:
 - (1) Reconstruction: adaptation by adoption of some non-Hawaiian modern technological advances, especially in urban centers.
 - (2) Revitalization: use of traditional cultural concepts and practices, where applicable, especially in rural areas.

III. Recommendations

A. Appropriate holistic awareness that health is only one aspect of well-being, and for Native Hawaiians as Native Hawaiians, pride of heritage is paramount.

Thus, the historical and cultural basis for our health plight must be the major consideration, and not merely concern for proximate causal factors, such as specified in the currently-fashionable government model of lifestyle, environment, health care and biological factors; with programs only in terms of physical health promotion, disease prevention and intervention.

B. Primary concern and kāko’o for ka po’e Hawai’i in the following main ways:

1. Input by ka po’e Hawai’i in all stages of planning and implementation, with the goal of control by Native Hawaiians ourselves in programs for ourselves. If “none are qualified,” then prompt on the job training should begin. This also includes respect for Native Hawaiian sensitivities in the process and use and strengthening of existing Native Hawaiian networks and support systems.

2. Build upon current Native Hawaiian cultural strengths by incorporation of appropriate mea pono Hawaii (valid Native Hawaiian values and practices), such as the basic concept of lōkahi with the cosmos, self, others, land and sea, and ‘aumakua in nurturing and maintaining mana; and ‘olelo Hawai‘i (Hawaiian language) as essential to restoring and maintaining our culture, and thus, our health.
3. Monitoring to assure that programs are of definite benefit to ka po‘e Hawai‘i, and not merely for promoting non Native Hawaiian researchers and sustaining administrative bureaucracies.
 - c. Systematic and continuous collection, tabulation, and analysis of critical health data by Native Hawaiians on Native Hawaiians for health needs assessments and specific health programs for Native Hawaiians, with the setting of priorities based on importance of need, expertise available, receptiveness of ka po‘e Hawai‘i, and availability of funds and other resources. The appropriate agency for these important tasks needs to be carefully determined.

D. Definition of realistic, practical and meaningful goals.

1. Emphasis on health promotion in the holistic sense, disease-prevention and control within appropriate cultural contexts, rather than exclusive end-stage intervention in hospitals.
2. Instead of mere improvement of health statistics, such as prolongation of life expectancy of ka po‘e Hawai‘i to that of haole, with nursing homes for abandoned elderly, we should realize that modern haole lifestyle factors may be largely responsible for ill health of ka po‘e Hawai‘i; and haole standards are not necessarily ideal or appropriate for ka po‘e Hawai‘i.
3. Avoidance of simplistic, romantically-idealized, politically-expedient “solutions,” that are at high risk for failure, such as the folly of the U.S. Leprosy Investigation Station at Kalawao from 1909 to 1911, and the Hawaiian Homes Rehabilitation Act of 1920.

E. Health education for Native Hawaiians by trained po‘e Hawai‘i.

1. Within the ‘ohana and at the local Native Hawaiian community level.
2. Emphasize appropriate Native Hawaiian cultural concepts, language and practices.
3. Use modern communication methods, where appropriate, such as sophisticated television programs, produced by po‘e Hawai‘i, using Native Hawaiian cultural motifs and ‘olelo Hawai‘i (Hawaiian language).
4. Target specific groups with specific health problems, such as: pregnant teenagers, preschool youngsters with dental caries, youths with cigarette, alcohol and drug-abuse; patients with diabetes, high blood pressure, obesity, and those at high risk for coronary heart disease and cancer.
5. Focus on: prudent nutrition, physical fitness, avoidance of harmful substances, stress-coping, self-care, understanding of common illnesses and complications, optimal use of health care resources, avoidance of faddism, commercialism, and excessive dependence on professionals.

F. Education of health personnel.

1. Of culturally-experienced and sensitive Native Hawaiians.
2. At all levels beginning with hiapo (eldest sibling), makua (parents, uncles, aunts), kūpuna (grandparents, elders), as teachers among peers and to juniors, within extended ‘ohana and local Native Hawaiian community existing social support networks.

3. Education of Native Hawaiian health professionals, to include not only physicians and nurses, but health educators, health aides, health advocates, health coordinators, health planners, health researchers, and health administrators.
4. Support appropriate training of respected native healers.
5. Native Hawaiian cultural awareness training of non-Native Hawaiian health professionals.

G. Coordination with existing health agencies and institutions, public and private, on specific health programs.

1. Appointment of Native Hawaiian health administrator in Hawai'i State Department of Health, at the state level and for each county, to coordinate government health programs for Native Hawaiians with non government programs, to avoid unnecessary duplication and to fill the gaps, maintain continuity and stability of needed and effective programs, and discontinue ineffective ones.

2. Native Hawaiian community inter-disciplinary Hale Ola (local family health centers) with local governing boards to assure availability, accessibility, acceptability within appropriate cultural context, focused on health-promotion and holistic medical care.

Some suitable models include: Hale Ola Ho'opākōlea, Hale Lōkāhi, Kahumana Counseling Center, Queen Lili'uokalani Children's Center Leeward Unit, Wai'anae Rap Center, Wai'anae Hawaiian Cultural Heritage Center, 'Ōpelu Fishing Project, Ka'ala Farm, Mākaha Farm, Wai'anae Adolescent Family Life Project, Nānākuli Fishing Village, Respite Care, Quick Kōkua, Family Planning Clinic, and Wai'anae Coast Comprehensive Health Center as units in the Wai'anae Coast Coalition for Human Services; Kupulani Project and Queen Lili'uokalani Children's Center Windward Unit; Waimānalo Maternal and Child Clinic and Youth Project; Dr. Emmett Aluli's "barefoot physician" approach on Moloka'i, and the Moloka'i Heart Study.

3. Investigation of reinstituting free medical care for needy po'e Hawai'i at the Queen's Hospital, Kapi'olani Hospital, and Lunalilo Home.

H. Integration of health programs with others concerned with:

1. Land: Regain and maintain Native Hawaiian land base through federal reparations for U.S. illegal overthrow of the kingdom and violation of Native Hawaiian indigenous people's rights. Return of federal ceded lands, pressure for state ceded lands and the Hawaiian Home lands, and proper protection of private Native Hawaiian lands, such as the Bishop Estate, Lili'uokalani Trust, Queen Emma lands, and threatened private Native Hawaiian family lands. Proper use of Native Hawaiian lands for Native Hawaiians: homes, access for farming, fishing, hunting, wood and plant-gathering; Native Hawaiian community facilities, such as pā, and marae (enclosed clearing), for Native Hawaiians' 'aha (gathering), hālāwai (meeting), hō'ike (show) celebrations, ceremonies; and for human services for Native Hawaiians.
2. Population control of further in-migration to prevent further unhealthful crowding and its other consequences, such as crime and destruction of natural resources.
3. Law: State civil rights law to assure representative health care for po'e Hawai'i. Laws to restrict sale and use of harmful substances, such as tobacco, alcohol, and specified harmful processed foods. Education of more Native Hawaiian culturally-sensitive attorneys, legal aides and mediators, with their placement in needed Native Hawaiian communities. Workshops on Native Hawaiian rights.
4. Political self-determination: Locally-elected Native Hawaiian councils and governing boards. Representation of po'e Hawai'i on all government bodies. Workshops on political organization and effective action on Native Hawaiian issues. Register every eligible Native Hawaiian to vote; provide transportation to voting booths.

5. Economic self-sufficiency: Job-training, especially for self-sufficiency in living from the land and the sea (vide infra – see below).
Native Hawaiian banks for loans at low interest to po‘e Hawai‘i.
Restraints on foreign multi-national control of Hawai‘i economy and especially of Native Hawaiian lands.
6. Environmental protection against pollution and destruction of our natural resources by government, developers, tourism, other commercial interests and the military.
7. Education: Hawaiian language and culture in all public and private schools, with instruction on Native Hawaiian rights and history of exploitation of Native Hawaiians, coordinated with health instruction at all levels. Increased alternative education programs for Native Hawaiian school age youngsters incorporating health instruction within Native Hawaiian cultural context.
8. Housing: Preference for needs of local Native Hawaiians over desires of malihini (newcomer) and greed of developers.
Incorporation of appropriate Native Hawaiian design and architecture by Native Hawaiians in all construction for Native Hawaiians.
9. Transportation: Limitation on automobiles and roads to reduce auto-related morbidity and mortality, and restrictions on destructive air and sea transportation facilities and practices.
10. Energy: More use of natural energy sources; less dependence on foreign oil.
11. Historic sites: Protection, restoration, maintenance and proper cultural use of Hawaiian historic sites in regular celebrations, ceremonies, cultural ‘aha (gathering), and historical dramas.
12. Communication: Appropriate representation (about 20%) of Native Hawaiian culture, language and personnel in all major media (TV, radio, newspapers).
Restriction of commercial advertising of health-harmful marketed products.
13. Lawai‘a (fishing): Restoration of nā loko (fishponds) to be maintained by po‘e Hawaii: subsidized cooperative lawai‘a until such programs become self-sustaining. Appropriate nurturing and protection of Native Hawaiian marine food sources.
14. Mahi‘ai (farming): Subsidized cooperative, diversified mahi‘ai for local needs, engaging Native Hawaiians, until farming programs become self-sustaining; promotion of individual home gardens, and small-scale farming for family subsistence of Native Hawaiian food sources, such as, taro, ‘uala (sweet potato), uhi (yam), ulu (bread-fruit), mai‘a (banana). Models include Ka‘ala and Makaha farms.
15. Language and culture: ‘Aha Pūnana Leo (language nest) for preschool, child-care Native Hawaiian culture language centers, conducted by trained Hawaiian language speakers and incorporating traditional Native Hawaiian cultural concepts, literature, and practices. Thus, a new generation of Native Hawaiian language speakers will replace the few remaining elderly ones.

PRELIMINARY PLAN FOR IMPROVING NATIVE HAWAIIAN HEALTH THROUGH HEALTH PROMOTION, DISEASE PREVENTION AND HEALTH PROTECTION

ALULIKE, INC.

Honolulu, Hawaii, December 1985

Reprinted by

Papa Ola Lōkahi

June 2016



Papa Ola Lōkahi
Nānā I Ka Pono Na Ma

Introduction

1779

"...we are...well authorized to lay down the population of this island (Hawai'i), at 200,000. Mowee (Maui) and Woahoo (O'ahu) are more extensive than Otaheite, apparently well cultivated and populous, let us suppose them 100,000 men each. Morotoi (Moloka'i) and A'toi (Kaua'i) are nearly the dimensions of Otaheite, but as the former of these islands did not appear to us well inhabited we will suppose them both to contain 100,000 souls."

The inhabitants of the islands Tahowrowa (Kaho'olawe), Ranai (Lana'i), Neeneehow (Ni'ihau), and Orecooa (Nihoa) will I think make up any deficiency in the above calculations; for Ranai is a larger island...and is said to contain 20,000 and it appeared well inhabited.

The above numbers collected together give half a million for the population of these islands"...Captain James Cook, 1779 (in *The Voyage of the Resolution and Discovery* (1967), p.619-620).

1855

"A subject of deeper importance, in my opinion, than any I have wither to mentioned is that of the decrease of our (Native Hawaiian) population. It is a subject, in comparison with which all others sink into insignificance; for, our first and great duty is that of self-preservation. Our acts are in vain unless we can stay the wasting hand that is destroying our people. I feel a heavy, and special responsibility resting upon me in this matter; but it is one in which you all must share; nor shall we be acquitted by man, or our Maker, of a neglect of duty, if we fail to act speedily and effectively in the cause of those who are everyday dying before our eyes"...Kamehameha IV, April 7, 1855 (in his speech before the opening of the Legislature of Hawaii 1841-1918 (1918), p.59).

1887

Year by year their (Native Hawaiian) footprints will grow more dim along the sands of their reef-sheltered shores, and fainter and fainter will come their simple songs from the shadows of the palms, until finally their voices will be heard no more forever...David Kalakaua, February, 1887 (in *Legends and Myths of Hawai'i* (1888), p.65).

1920

"The Hawaiian people are a dying people. Just at a time the American people are trying to do something for the dying people of Europe. They are reaching out across the Atlantic and are trying to help the Belgians, to help the French, and to help other races in Europe, and I would like to have the Committee just pause for a moment and look back at the Hawaiians...a noble race"...The Honorable John Wise in testimony before the House of Representatives, Committee on Territories, 66th Congress (Bills, Reports, Hearings and Acts: Hawaii (1921), p. 169).

1983

"Native Hawaiians continue to experience a form of fatal impact usually associated with the last century. Neither Hawaiian nor Western medicine has effectively halted the damage"...Native Hawaiian Study Commission in its Report, Volume 2 (1983), p. 149-150.

These glimpses of the past are like portholes in time and provide the basis of concern for this report.

At the time of his arrival in Hawai'i in 1778, Captain James Cook estimated that the Native Hawaiian population numbered close to 500,000 people. The first reliable estimate of the population based on adequate observation was made by the missionaries in 1823 and was given at 142,650. This reflects more than a fifty percent decline in population during the 45-year interval after Cook's first visit to the islands. The official census of 1853 placed the Native Hawaiian population at 71,019, again reflecting almost a fifty percent reduction in population since the 1823 estimate. In 1893, the population "bottomed out" at 34,547. In the intervening years since 1893, the Native Hawaiian population in Hawai'i has gradually recovered and grown to its current size of more than 185,000.

Yet, despite this increase, an abundance of health concerns and problems continue to plague Native Hawaiians.

In an effort to begin addressing specific areas of health concerns and problems afflicting Native Hawaiians as identified by a number of Native Hawaiian groups, organizations and individuals, the U.S. Senate Appropriations Committee included a directive to the U.S. Department of Health and Human Services in its FY1984 Supplemental Appropriations Bill (P.L.98-396) calling for the department to conduct a “comprehensive review of the unique health care needs of Native Hawaiians.”

Under the direction of the Assistant Secretary for Health and Region IX of the Public Health Service, ALU LIKE, Inc., a Native Hawaiian organization, working with the Wai‘anae Coast Comprehensive Health Center, formed the Native Hawaiian Health Research Consortium composed of professionals in the state concerned with Native Hawaiian health issues.

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Beginning work in January 1985, the Consortium directed its efforts to completing five major tasks:

1. To identify, collect and analyze existing data on the health of Native Hawaiians from sources such as the Cancer Research Center, the Health Surveillance Program, and other health programs and agencies, focusing on mortality, morbidity, prospective cohort on habits and socio-economic variables.
2. To conduct an inventory of published and unpublished studies on topics related to the health of Native Hawaiians.
3. To compute statistics on the health status, service needs and utilization of Native Hawaiians for different time periods in order to evaluate trends and patterns.
4. To compare and analyze findings from data files and studies in terms of health status and service needs which have not been met.
5. To make recommendations for service/program needs and the mechanisms to meet these needs. In November 1985, the results of these activities were reviewed and analyzed in a day-long conference on Native Hawaiian health at the East-West Center in Honolulu. Health professionals and members from the Native Hawaiian community provided input into the findings and recommendations of the consortium reports. The reports have been revised to reflect that input.

The final report of **E OLA MAU: The Native Hawaiian Health Needs Study** consists of five task force reports focusing on specific Native Hawaiian health concerns:

Strategic Health Plan Task Force Report
Historical/Cultural Task Force Report
Medical Task Force Report
Mental Health Task Force Report
Nutritional/Dental Task Force Report

This volume provides a brief summary of the health findings and recommendations of the other task forces and a preliminary plan for developing a mechanism to improve Native Hawaiian health through health promotion, disease prevention, and health protection.

Members of the Strategic Health Plan Task Force are:

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As a final note, reviewers are directed to Section VI of this report of the Study where brochures and pamphlets of organizations, agencies, and projects mentioned in the text have been appended for further review.





Part I | Native Hawaiian health profile

I. Native Hawaiian health profile

A. CONTEXT FOR HEALTH PLANNING

Three themes flow throughout this Plan: (1) that health is a holistic concept which applies to the total being, individually, and to the total community, collectively; (2) that culture plays a vital and unique role for Native Hawaiians in health issues; and (3) that the federal government and the State of Hawaii have had a continuing relationship with Native Hawaiians and a responsibility for addressing Native Hawaiian health concerns.

1. A Holistic Health Approach

In 1979, the U.S. Surgeon General articulated as federal policy a holistic approach to health. The model put forth a number of different mechanisms which could be directly related to identified health factors with equally identifiable health effects (see Table 1).

The model was a useful one in describing the responsible factors for good health and revolutionary in the sense that it began to recognize how collective social factors such as the distribution of power and wealth or the loss of one's native culture can influence health outcomes for individuals.

An additional model addressing health concerns of individuals and communities has been developed by George Albee of the University of Vermont. His model, developed over a period of years, prescribes a formula for reducing the incidence and prevalence of psychopathology, shown as follows:

$$\begin{array}{ccccccc} & \text{ORGANIC} & & & & & \\ & \text{FACTORS} & + & \text{STRESS} & + & \text{EXPLOITATION} & \\ \text{INCIDENCE} & & & & & & \\ * & & & & & & \\ & \text{SOCIAL} & & & & & \\ & \text{COPING} & + & \text{SELF} & + & \text{SUPPORT} & \\ & \text{SKILLS} & & \text{ESTEEM} & & \text{SYSTEMS} & \end{array}$$

The formula has certain similarities to traditional public health strategies which involve reducing the power of “noxious agents” (defined by the numerator) and increasing “resistance” in the hosts (defined by the denominator). Generally, the items noted in the numerator are negatives to health while those in the denominator are positives to health. For both treatment and prevention, this model's prescribed strategy is the same; reducing or eliminating damage causing organic factors, stress, and exploitation, while increasing coping-skills, self-esteem, and support systems.

Both models are examples of a new way of thinking about health and clearly demonstrate the need for developing a holistic approach for addressing the health concerns and needs of populations. Many identified concerns and needs may be manifestations of much larger social, political, and/or economic concerns. These possible underlying causes of health problems only can be properly addressed through a holistic approach.

As the findings of this study will illustrate, this type of approach is the only one which can effectively encompass the history, culture and health-related needs of Native Hawaiians.

2. The Cultural Equation

Native Hawaiians and their Polynesian brethren have had a distinct and continuous culture for more than two thousand years. Native Hawaiian culture as a distinct entity within the Polynesian family has been evolving for more than 1,500 years. Strong cultural concepts relating to health have evolved and developed. Good health was viewed as something which emanated from positive and proper relationships between oneself and one's total environment as defined by the physical and metaphysical concepts and perceptions of that time. Health was not defined as it is in the Western sense as a separate entity distinguishable from other social concepts. Instead, it was integrated into the religious and social fabric of daily living and, generally, health promotion, disease prevention, and health protection were the responsibility of the extended family.

In more recent times the traditional Native Hawaiian cultural patterns have been severely disrupted by rapid modernization and change. This loss of culture has been found to have many adverse effects on Hawaiian social systems, families and individuals. A recent study by the Kamehameha Schools/Bishop Estate, the Native Hawaiian Educational Assessment Project (1983), documented those effects on both educational outcomes and health. In testimony before the Senate Select Committee on Indian Affairs (1985), Bishop Estate Trustee Myron Thompson described how culture loss may be seen as a system affecting individuals through such mechanisms as family stress (see Figure 1 in Part V and attachment “Culture Loss and Stress Among Native Hawaiians” in Part VI).

It is important to emphasize that the traditional Hawaiian system of health concepts and health care did not “fail” the Hawaiians. As one part of the larger culture loss, it was relegated to a position inferior to the perceived superiority of the western primary care system. The fact that Native Hawaiian culture was not completely lost and is now undergoing an existing revitalization indicates that Western medicine may yet have the chance to learn from the more holistic views of the Native Hawaiians.

3. The Federal-State Responsibility: A Shared Commitment

a. The Federal Role

As aboriginal peoples of the islands which now comprise the State of Hawai‘i, Native Hawaiians, like their American Indian, Eskimo, and Alaskan Native brethren, are Native American peoples. And, while each of these peoples’ paths has been unique in regards to relationships with the United States Government, there is ample precedent and legal justification to indicate the responsibilities assumed by the Federal Government for its native peoples.

The Native Hawaiian experience is different from that of the American Indian, Eskimo, or Alaskan Native but no less indicative of a relationship that has developed over a period of more than 150 years. Official relations between the Kingdom of Hawai‘i and the United States began as early as 1826 with a mutual agreement of “Articles of Arrangement. “As history moved Hawai‘i through a political sequence from Kingdom to Provisional Government, to Republic to Territory and, most recently, to Statehood, the nature of the United States Government’s relationship with Hawai‘i shifted from one of diplomatic respect for sovereignty between two equal nations to one of the United States Government responsibility for a Native American people. As this political transition was occurring, Hawaii’s social fabric was being altered radically. Foreign people with foreign ideas and concepts took control and Native Hawaiians became a minority in their own land. Politically, institutionalized Native Hawaiian control was lost with the overthrow of the monarchy in 1893 aided by American officials and armed forces. Economically, Native Hawaiian control had already been lost well before the 1893 overthrow to foreign business interests (primarily American and English). Land, the most valuable and viable economic resource of Native Hawaiians, began to slip from Native Hawaiian to foreign control with the passage of a series of land acts beginning with the “Great Mahele” of 1848. While this period marked the beginning of large corporate foreign business development in Hawai‘i, it also initiated the beginnings of a land alienation process, the effects of which are still evident today. These early political and economic events had social impacts as well. Native Hawaiian culture was suppressed by religious and political beliefs and replaced by American-style Western values. In order to survive, many Native Hawaiians abandoned their culture in favor of the dominant one while others simply gave up. The results were devastating. By 1919, the death rate for Native Hawaiians was more than twice that of any other ethnic group, and the population of full blooded Hawaiians had dropped from about 142,600 to 22,600 within three generations. Native Hawaiians pressed the Federal Government for action to save their “dying race.” Congress held hearings in 1920 on how best to turn around these alarming health statistics (see Figure 2).

After much discussion and compromise, Congress enacted the Hawaiian Homes Commission Act in 1921 in an attempt to “rehabilitate” Native Hawaiians. As then Secretary of the Interior Franklin K. Lane testified before the House Committee on Territories:

One thing that impressed me...was the fact that the natives of the islands who are our wards...and for whom in a sense we are trustee, are falling off rapidly in numbers and many of them are in poverty...

It is clear from the Congressional reports of the day that Congress recognized the declining health and well-being of Native Hawaiians and attempted "rehabilitation" through the granting of land for homesteading. While it is debatable whether or not the Act has restored vitality, it is clear that the Act did signify the Federal Government's concern for the health and well-being of Native Hawaiians.

Between 1921 and 1975, the Federal Government provided little support for Native Hawaiians and Native Hawaiian programs. In 1975, however, the U.S. Department of Health, Education, and Welfare (now the U.S. Department of Health and Human Services) provided financial assistance to ALU LIKE, Inc. to conduct the first

comprehensive Needs Assessment of the Native Hawaiian Community. That assessment provided data for federal agencies to begin addressing Native Hawaiian needs in education, employment, economic development, health, housing, and native rights. Subsequently, Native Hawaiians have been included in several Congressional acts and resolutions which have brought federal resources to focus on Native Hawaiian concerns. The major acts and resolutions which have recognized Native Hawaiians and Native Hawaiian concerns include:

- Hawaiian Homes Commission Act (July 9, 1921)
- Hawaii National Park Extension Act (June 30, 1938)
- Hawaii Admissions Act (March 19, 1959)
- Community Services Act of 1974 (January 4, 1975)
- Comprehensive Employment and Training Act (August 5, 1977)
- Native American Religious Freedoms Act (August 11, 1978)
- Youth Employment Act (October 27, 1978)
- National Institute on Drug Abuse Legislation (January 2, 1980)
- Native Hawaiian Study Commission (December 22, 1980)
- Job Training Partnership Act (October 12, 1982)
- Library Services and Construction Act (October 17, 1984)
- Carl D. Perkins Vocational Education Act (October 19, 1984)

Rehabilitation for Native Hawaiians in its broadest sense has not, as yet, been achieved. While important strides have been made, the results of this preliminary health assessment indicate that without a concerted effort by the Federal Government, working in conjunction with the State of Hawaii and the Native Hawaiian community, rehabilitation is still a distant reality.

b. The State's Role

The state has a legal responsibility and a social mandate to address Native Hawaiian health concerns. Indeed, recent legal opinions support the position that the state may be in breach of its established trust responsibilities to Native Hawaiians if it fails to do this.²

The current policy of the State Department of Health is to not focus on needs of specific ethnic groups but rather to provide services “equally to all groups.” This is predicated on Constitutional law forbidding racial discrimination. Yet, special programs with preferences to Native Hawaiians, and other Native Americans have been enacted and have been upheld by the courts. This has not been based on racial reasons but, rather, because of the special legal and political status that native groups have in American law. The U.S. Constitution recognizes this special status and the U.S. Supreme Court has repeatedly reaffirmed it in recent years.³

With the promulgation of the Hawaii Admissions Act in 1959, the State of Hawaii assumed special responsibilities to Native Hawaiians. As such, the Department of Hawaiian Home Lands and the Office of Hawaiian Affairs are viewed as state agencies or agents of the state.

It is pertinent to note that in addition to Hawaii, there are 23 states which also recognize and provide programs to Native American peoples in their respective states.⁴

Further, the Hawaii Supreme Court has recognized Native Hawaiians as Native Americans and noted, “essentially we are dealing with relationships between governments and aboriginal peoples.”⁵

Given these legal opinions that Native Hawaiians are Native Americans and that, as such, they have special relationships with federal and state governments which allow for special programs, the current policy and practice of the State Department of Health in not specifically addressing identified health concerns of Native Hawaiians may be considered as inappropriate. There would seem to be an abundance of legal precedent for the State Department of Health to begin doing so.

B. NATIVE HAWAIIAN HEALTH ASSESSMENT FINDINGS

In order to conduct this study, a division of labor was established which created a number of Task Forces to study specific aspects of Native Hawaiian health. There was, of course, some overlap among and between them. The findings and recommendations in the Historical/Cultural Task Force Report, for example, are considered fundamental to an understanding of all the others. Similar problems are cited in more than one Task Force Report, and some of the recommendations for action are similar.

In most cases, the overlap between Task Force reports emphasizes the interrelationship between physical health, mental health, and nutrition/dental health with the underlying unifying factors of history and culture. Because they are sometimes repeated, some of the findings may seem overstated. Others may seem understated. For example, each of the Task Forces mentions the over representation of Native Hawaiians in statistics on alcohol and drug abuse. Yet, the pervasive influence of this problem on other health needs may seem understated since it was extremely difficult to find good data and documentation and to frame the available data in such a way that it became a priority for anyone of the Task Forces. Nonetheless, taken together, the evidence is strong that it should be considered a high priority in health planning.

Another issue with which all the Task Forces had to deal was that of definitions. For the study as a whole, the term “Native Hawaiian” is defined, following the precedent set in federal legislation, as:

“Any individual any of whose ancestors were natives, prior to 1778, of the area which now comprises the State of Hawaii.” (Carl D. Perkins Vocational Education Act of 1984)

This inclusive definition also mirrors social and cultural reality in Hawai‘i. Nonetheless, many of the agencies and institutions in the state which were primary data sources have differing operational definitions. This made data comparability problematic. For some of the findings, comparisons within the Native Hawaiian group in order to determine what might be higher risk sub-groups are possible. For other findings, such comparisons are made only to enhance planning for maximally effective future health care. Along with all the other findings, they should be considered in the light of present data limitations.

Given these caveats, then, the findings of each of the Task Forces are presented in summary:

1. Historical/Cultural Task Force

Ka po‘e Hawai‘i (Native Hawaiians) were generally healthy people. They had adapted effectively to island ecosystems for more than 1,500 years... Religion dominated all aspects of life and stemmed from the basic concepts of *lōkahi* (unity) with a living, conscious and communicating cosmos; polytheism, animism, evolution with dualism; harmony with maintenance of *mana* (special energy) and wellness, disharmony with loss of *mana* and illness; continuous communication with the spiritual realm, *kapu* (sacred law) as a means of preserving *mana* for the common good; collective interdependence with *‘ohana* (family), nature, *‘aumākua* (ancestral gods), *kahuna* (priest-specialists), individual self reliance; recurring life cycle of rebirth, growth, maturation, mating, parenting, death, eternal *ea* (spiritual life force) and *ola* (physical life) in *kinolau* (many forms). These concepts were the basis for generally favorable health practices: high fibre, high starch, low fat, low sugar diets with ample protein and adequate mineral (variable sodium) and vitamin nutrition; fastidious personal hygiene; vigorous physical fitness in enjoyable work and recreation; generally effective stress coping; strict public sanitation and environmental protection in an *ahupua‘a* (mountain to sea resource concept) cooperative subsistence economy without private land ownership; unknowing control of potentially harmful micro-organisms; and holistic medical care and medical practices appropriate for the setting and time. These included –

- (1) Integrated psychospiritual methods including prayer, revelation, suggestion and extra-sensory perception;
- (2) Physical methods including careful observation and palpation, body molding, massage, and manipulation; clyster-enema and hydro-thermo-heliotherapy; and fracture setting;
- (3) Pharmaceuticals as part of rituals with symbolism including the empirical use of the narcotic *‘awa*, carthartic *kukui* and *koali*, poultice *pōpōlo*, *koali*, and *noni*; mineral *alae*; and anti-diarrheal *pia*;
- (4) Surgery including incision of abscess; prepuce subincision; minor resection; amputation; and probable trephining;
- (5) Experimentation including the systematic observation of all phenomena with detailed nomenclature and classification; empirical clinical trials with medicinals; autopsies; and animal research;

- (6) Education including 'ohana training for each child in self-care by experience kupuna (family elders) and medical training for selected haumana (students) by kahuna lapa'au (health specialists) at heiau ho'ola (healing temples).

The negative Western impacts on Native Hawaiians, generally, and on Native Hawaiian health, specifically, are documented in the various Task Force Reports of this Study. It is important to note, however, that Native Hawaiian culture continues to survive. The language is spoken, deep spirituality, reverence for the land and nature, and group affiliation persist, and many of the traditional health concepts reiterated earlier are still practiced. These concepts have worked for hundreds of years and herein lies their strength. Western medicine in the Native Hawaiian context is still but an infant by comparison.

Culture, then, for Native Hawaiians as it relates to their health is an important one, and one which policy-makers and heal the professionals cannot disregard. Culture provides the framework from which to proceed if improved Native Hawaiian health is to become a reality.

2. Mental Health Task Force

The Task Force findings are as follows:

- a. There is a difference between Western and Native Hawaiian mental health concepts. Fundamental errors are made when mental health for Native Hawaiians is viewed within a Western framework.
- b. There is a wealth of materials in the Hawaiian language which can be used to understand Native Hawaiian views of mental health. The materials need to be translated into English and disseminated to a wider audience including mental health professionals.
- c. Existing mental health data are inadequate to understand fully the nature of the mental health of Native Hawaiians and to derive solutions for the mental health issues confronting Native Hawaiians.
- d. Native Hawaiians have high rates for certain mental health problems including suicide, alcohol and drug abuse, crime, child abuse, school adjustment problems, and certain mental illnesses.
- e. Native Hawaiians are over-represented in a series of negative economic and social indicators. These indicators show that many of the problems confronting Native Hawaiians may be attributed to their relative low social and economic position within modern Hawai'i society.
- f. Generally, existing mental health services are insensitive to the mental health issues confronting Native Hawaiians. The mental health system is indifferent to Native Hawaiian values, treatment goals, problem solving methods, and communication methods.
- g. Native Hawaiians, generally, do not use existing mental health services because of cultural barriers. Many Native Hawaiians prefer the personal involvement of traditional healers who offer high personal involvement, informality, social support, reassurance, and acceptance.
- h. Native Hawaiians, when conditions permit, have a history of resolving their own problems; and activities within the past 15 years have demonstrated a struggle for empowerment, cultural pride, and competence. These activities also demonstrate the vibrancy within the Native Hawaiian community to define issues and take appropriate actions, given adequate social and financial support.
- i. Native Hawaiian cultural identity and pride are born out of traditional Hawaiian concepts and relationships. Problems associated with mental health will not be fully alleviated until necessary action is taken to reunite Native Hawaiians with those concepts and practices associated with land ('āina) and nature.

3. Medical Task Force

The Task Force findings are as follows:

- a. Native Hawaiians experience disproportionately higher rates of several common chronic illnesses, including heart conditions, hypertension, asthma, diabetes, gout, malignant neoplasms, bronchitis/emphysema, back problems, and varicose veins.
- b. Native Hawaiians experience greater activity-limitation due to chronic conditions than do other ethnic groups in Hawai'i.
- c. Native Hawaiians experience disproportionately high rates of death due to accidents.
- d. Native Hawaiians have higher crude birth rates, fertility rates, and born children-to-women rates than the state's average.
- e. Native Hawaiians have a greater number of pregnancy risk factors such as: teen pregnancies and teen births, illegitimate births, and pregnant women having late or no prenatal care, and having higher percentages of

- smokers and drinkers during pregnancy. As a result, Native Hawaiian women are more likely to develop toxemia and urinary tract infections during pregnancy. Women over 35 are more likely to experience labor and delivery complications.
- f. Native Hawaiians have higher infant mortality rates than other major ethnic groups, including higher rates of death due to immaturity and incidences of sudden infant death syndrome, and disproportionately high rates of congenital anomalies.
 - g. Native Hawaiians have higher age-adjusted prevalence rates for diabetes than other ethnic groups in Hawai'i and experience the highest risk if they are over age 45, if they are residing in rural areas, and if they are female from lower income families.
 - h. Native Hawaiians have higher age-adjusted rates of hypertension and heart disease than other ethnic groups in Hawai'i. Part-Hawaiians have higher age-adjusted rates of hypertensive heart disease than Hawaiians, and Full Hawaiians have considerably higher age-adjusted heart disease rates than Part-Hawaiians. Disproportionate higher rates of hypertension and heart disease occur at younger ages and are even evident before age 45. High risk was also found among Part-Hawaiian women over age 45 and urban dwellers. Some of the factors associated with these findings are: consumption, obesity, fat and salt intake, and lack of participation in hypertension screening programs.
 - i. Native Hawaiians experience higher cancer rates than other ethnic groups for cancers of the stomach, lung, and female breast and cervix. Full Hawaiians have higher rates of cancer than Part-Hawaiians. Incidence of cancer among Native Hawaiians begins in earlier age categories than for other ethnic groups.
 - j. Native Hawaiian men are at high risk for esophageal and lung cancer. Full Hawaiian females who are obese have high risks for breast cancer. Endometrium cancers and male prostate cancers are greater for Full Hawaiians than for other groups. Some of the contributing factors are:
 - 1) Native Hawaiians tend to be diagnosed at a later stage of cancer than other ethnic groups.
 - 2) Native Hawaiians have poorer survival rates for three of the four common cancers when compared with individuals from other ethnic groups diagnosed at the same stage of disease.
 - 3) Native Hawaiians generally are not familiar with the risk factors associated with cancer, the major symptoms of cancer, and methods of early detection.
 - 4) Native Hawaiian women are under-utilizing breast cancer screening programs
 - k. There are barriers to health service utilization by Native Hawaiians. The reasons for this are many and data indicate that:
 - 1) Native Hawaiians resist and under utilize health care provided through the typical service structure due to historical, cultural, and/or bureaucratic barriers. Consequently, participation is low even in health education and screening programs offered at no cost and/or during extended hours.
 - 2) Native Hawaiians are believed to be less likely to participate in health promotion activities such as weight-reduction, exercise, stress-management and stop-smoking programs sponsored by the major medical centers in Honolulu.
 - 3) Native Hawaiians resent outsiders who try to change cultural and/or behavioral attitudes. Health care providers cannot assume that their credentials and expertise are enough to convince Native Hawaiians to abandon a practice and/or lifestyle.
 - 4) Many Native Hawaiians experience geographic and transportation barriers to using medical services, especially in rural areas on Neighbor Islands.
 - 5) Many Native Hawaiians experience financial barriers to using medical services due to high out-of-pocket costs and to inadequate medical insurance coverage. Although Hawaii State law requires medical insurance coverage for employees working 20 hours or more per week, a disproportionate number of Native Hawaiians are unemployed and/or marginally self-employed in fishing or agriculture.
 - l. Native Hawaiians do utilize programs where outreach education, screening, and referral services are provided once personal relationships with members of the community have been established and where services are provided through community groups and by Native Hawaiians.

4. Nutrition/Dental Health Task Force

The Task Force findings are as follows:

- a. There is a critical lack of knowledge of risk factors affecting Native Hawaiian diet and health. Little or no data exist on the diets of pregnant Native Hawaiian women. Data on the dietary intake of Native Hawaiian infants and children are outdated. There has been no research on better ways to promote healthier Native Hawaiian lifestyles within a culturally appropriate framework.
- b. There is a need to relate available data on diet and the incidence of heart disease, cancer, diabetes, arthritis, and gout among Native Hawaiians. There is currently no way to systematically monitor and evaluate programs aimed at improving the nutritional health of Native Hawaiians. Data for maternal infant child (MIC) projects (Waimanalo, Nanakuli, and Hilo), WCCHC, WIC, and other health centers have not been systematized, collected, and reported upon for Native Hawaiians. The existing Health Surveillance Survey conducted by the State Department of Health is not currently able to include dietary information on a regular basis.
- c. Native Hawaiian women generally receive poor care and health education during pregnancy. Native Hawaiians have disproportionately high rates for neonatal deaths and infant deaths and low birth weights. Native Hawaiian mothers are breast-feeding but tend to cease this practice early after birth. There is evidence of malnutrition among young Native Hawaiian children. Finally, as has been noted earlier, Native Hawaiians account for the highest “high-risk” pregnancies including teenage and illegitimate pregnancies in the State.
- d. Native Hawaiian women, infants, and children benefit from such programs as MIC, WIC, School Lunch, School Breakfast, Expanded Food and Nutrition Education Program and Nutrition Education Training programs. Many Native Hawaiians have used the WIC program in Waimanalo, Oahu. The WIC Program, generally, has reported improvements in several outcomes, including a greater incidence of breast-feeding and heavier infants, and better diets.
- e. Native Hawaiian diets, generally, are deficient in essential nutrients. Native Hawaiian pre-schoolers have been found to have diets deficient in calcium, riboflavin, and vitamins C and A. Native Hawaiian school-age children have diets low in calcium and iron.
- f. Native Hawaiian school children, generally, have higher consumption of fats and calories than other ethnic groups in the state. Several studies also indicate that Native Hawaiian children suffer disproportionately from obesity. There is evidence that Native Hawaiian adults have a disproportionately high caloric intake particularly associated with alcohol intake. Adults, also, have been found to have elevated triglyceride levels and diastolic blood pressure related to obesity.
- g. Certain dietary and lifestyle factors have been identified as creating particularly high risk for coronary heart disease in Native Hawaiians. These factors include cigarette-smoking, high blood cholesterol, linoleic acid (negatively related), saturated fats, stress, and greater body surface area.
- h. Native Hawaiians are over-represented among those suffering from chronic diseases for which dietary and lifestyle causal factors have been identified. These include breast cancer, lung cancer, stomach cancer, cardiovascular renal disease, myocardial infarction, diabetes, arthritis, and gout.
- i. Native Hawaiians have a disproportionately high rank in poor dental health status as measured by caries attack rates, DMF, periodontal index and dental hygiene scores. While historically, Native Hawaiians experienced good dental health with little tooth decay, that has changed with diet. Today’s Native Hawaiian children are the highest consumers in all ethnic groups of sweet beverages, dessert items, snack foods, candy, and gum. This has been associated with Native Hawaiian children having a high degree of plaque formation in conjunction with decayed, missing, and/or filled teeth.
- j. None of the existing programs in dental education has a Hawaiian cultural component. While these programs have been identified as community efforts, none has developed any training element based on Hawaiian cultural beliefs and/or practices.
- k. Native Hawaiians may have inadequate dental care due to lack of insurance coverage. A State Department of Health survey in 1979 found that some 48% of the state’s population was not covered by dental insurance.
- l. Data on dental health in Hawai’i are generally lacking, particularly as they apply to Native Hawaiians and other ethnic groups. The State Department of Health’s Surveillance Program does not regularly include questions on dental health.



Part II

Recommendations and models for Native Hawaiian
health promotion, disease prevention, and health protection

II. Recommendations and models for Native Hawaiian health promotion, disease prevention, and health protection

A. COMMITTEE RECOMMENDATIONS FOR NATIVE HAWAIIAN HEALTH

This Study has developed specific recommendations for policy-makers and health planners to review and consider. When identifiable, a target group, entity, or agency; potential resources; and prospective lead agencies have been noted:

List of Agency Acronyms

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration (DHHS)
CDC	Centers for Disease Control (DHHS)
DHHL	Department of Hawaiian Home Lands
DHHS	Department of Health and Human Services
DOE	Hawaii State Department of Education
DMH	Hawaii State Department of Health, Division of Mental Health
DOH	Hawaii State Department of Health
DOT	Hawaii State Department of Transportation
EPA	Environmental Protection Agency
HCFA	Health Care Financing Administration (DHHS)
HRA	Health Resources Administration (DHHS)
HSA	Health Services Administration (DHHS)
HSI	Hawaiian Studies Institute (UH)
HSIA	Hawaiian Service Institutions and Agencies (ALU LIKE, Inc., Department of Hawaiian Home Lands, The Kamehameha Schools/Bishop Estate, Queen Liliuokalani Children's Center, Lunalilo Home, Bishop Museum)
KS/BE	The Kamehameha Schools/Bishop Estate
NHLC	Native Hawaiian Legal Corporation
NIH	National Institute of Health (DHHS)
NIMH	National Institute of Mental Health (DHHS)
OHA	Office of Hawaiian Affairs
OHDS	Office of Human Development Services (DHHS)
PHS	Public Health Service (DHHS)
UH-SOM	University of Hawaii, School of Medicine
UH	University of Hawaii
WCCHC	Waianae Coast Comprehensive Health Center

I. Task Force Recommendations

RECOMMENDATION

1.0 HISTORICAL/CULTURAL

1.1 That there be an appropriate holistic awareness that health is but one aspect of well-being; for Native Hawaiians, pride of heritage is paramount. Thus, there should be a focus on the historical and cultural basis for the current health plight on Native Hawaiians and not merely a concern with proximate causes.

TARGET AGENCY
State DOH, State DOE

POTENTIAL RESOURCES
HSIA, OHA, DHHS, HSI

LEAD AGENCY(IES)
State DOH

1.2 That there be a systematic and continuous collection, tabulation and analysis of critical health data, by Native Hawaiians, for health needs assessments and specific health programs for Native Hawaiians. The priorities for these programs should be based on the magnitude of need, expertise available, receptiveness of the Native Hawaiian community, and availability of funds and other resources.

TARGET AGENCY
Legislature

POTENTIAL RESOURCES
HSIA, OHA, DHHS, HSI

LEAD AGENCY(IES)
State DOH

1.3 That there be clearly defined realistic, and meaningful goals for Native Hawaiian health programs. The emphasis of such programs should be on health promotion, disease prevention, and health protection within the appropriate cultural context and not on exclusive end-stage intervention in hospitals. Embracing negative aspects of modern western lifestyle is largely responsible for the ill health of Native Hawaiians and western methods of treatment are not necessarily ideal or appropriate for Native Hawaiians.

TARGET AGENCY
Legislature

POTENTIAL RESOURCES
HSIA, OHA, DHHS, HSI

LEAD AGENCY(IES)
State DOH

1.4 That there be culturally based health education programs developed and maintained by Native Hawaiians and targeted to Native Hawaiian families and communities. Such program should integrate cultural concepts with specific health problems such as nutrition, physical fitness, avoidance of harmful substances, stress-coping, self-care, understanding of common illnesses and complications, sexual identity, death and dying concepts, pre-natal and child birth care, optimal use of health care resources, avoidance of faddism, commercialism, and excessive dependence of professionals. Modern communication systems such as television should be used in developing these programs.

TARGET AGENCY
State DOH, Community Health Care Organizations, Legislature, State DOE

POTENTIAL RESOURCES
HSIA, OHA, DHHS, HSI, KS/BE

LEAD AGENCY(IES)
State DOH,
Native Hawaiian Organizations

1.5 That there be encouragement for learned Native Hawaiians to teach and instruct other Native Hawaiians in healthrelated areas at all levels including hiapo (eldest sibling), makua (parents, uncles, aunts), and kupuna (grandparents, elders).

TARGET AGENCY
State DOH, Community Health
Care Organizations, Legislature,
State DOE

POTENTIAL RESOURCES
HSIA, OHA, DHHS,
HSI, KS/BE,
Hawaiian Civic Clubs

LEAD AGENCY(IES)
State DOH, Native
Hawaiian Organizations

1.6 That there be cultural awareness training for Native Hawaiian and non-Native Hawaiian health professionals including physicians, nurses, health educators, health aides, health advocates, health coordinators, health planners, and health administrators. This training should provide liaison with effective and respected native healers.

TARGET AGENCY
State DOH, Community
Health Care Organizations

POTENTIAL RESOURCES
HSIA, OHA, HSI,
KS/BE, DHHS

LEAD AGENCY(IES)
State DOH, Native
Hawaiian Organizations

1.7 That there be coordination among existing health agencies and institutions in their service delivery to the Native Hawaiian community. This includes having agencies and institutions coordinate with the Native Hawaiian community for the services and programs rendered to it and providing the Native Hawaiian Community such health service as was the intent of the founders of some of these health care institutions.

TARGET AGENCY
Health Organizations
and Agencies

POTENTIAL RESOURCES
HSIA, OHA,
DHHS, WCCHS

LEAD AGENCY(IES)
Native Hawaiian
Groups, HSIA, OHA

1.8 That there be developed an integrated approach to health programs in the Native Hawaiian community. This includes developing health programs in conjunction with concerns relating to land, urbanization, law, and the justice system, self-determination, economic self-sufficiency, environmental protection, education, housing, transportation, energy, historic and archaeological sites, lawai‘a ana (fishing), mahi‘ai ana (farming), and language and culture.

TARGET AGENCY
OHA, HSIA, HSI

POTENTIAL RESOURCES
State Agencies, Federal Agencies,
Private Groups and Organizations

LEAD AGENCY(IES)
OHA

1.9 That there be meaningful participation by Native Hawaiians individually and collectively at all levels of program planning and development. There should be motivated participation at decision-making levels.

TARGET AGENCY
State DOH, Community Health Care Organizations

POTENTIAL RESOURCES
Native Hawaiian Groups and Organizations

LEAD AGENCY(IES)
OHA, HSIA, HSI

2.0 MENTAL HEALTH

2.1 That autonomous mental health and healing services which are committed to Native Hawaiian culture, history, language, and lifestyles be developed and promoted.

TARGET AGENCY
State DOH, Community Health Organizations

POTENTIAL RESOURCES
NIMH, State DOH, Legislature

LEAD AGENCY(IES)
Native Hawaiian Agencies, Community Action Groups

2.2 That Native Hawaiian values and lifestyles to promote Native Hawaiian identity, pride, assertiveness, and power be perpetuated.

TARGET AGENCY
Community at Large

POTENTIAL RESOURCES
OHA, State DOH, DMH

LEAD AGENCY(IES)
Native Hawaiian Agencies, HSI

2.3 That educational training programs to facilitate the entrance of Native Hawaiians into mental health professions such as psychology, psychiatry, social work, and research be developed.

TARGET AGENCY
State DOE, UH, Private Schools

POTENTIAL RESOURCES
NIMH, KS/BE

LEAD AGENCY(IES)
Native Hawaiian Agencies, University of Hawaii, DMH

2.4 That mental health professionals rendering services to Native Hawaiians be certified in cultural knowledge, history, and lifestyle.	TARGET AGENCY State DOH
	POTENTIAL RESOURCES DMH
	LEAD AGENCY(IES) DMH, Native Hawaiian Agencies
2.5 That third party payments for treatment services based on traditional Hawaiian orientation and practices be legitimized.	TARGET AGENCY Legislature, State DSSH
	LEAD AGENCY(IES) DOH, Native Hawaiian Agencies, State Legislature
2.6 That political, economic, and social competence among Native Hawaiian people be developed and promoted.	TARGET AGENCY Community at Large
	POTENTIAL RESOURCES KS/BE, OHA, Native Hawaiian Fundraisers
	LEAD AGENCY(IES) Hawaiian Civic Clubs, HSIA, OHA, HSI
2.7 That students in Hawaii's school systems and University of Hawaii systems be required to take courses in Hawaiian history, language, and culture.	TARGET AGENCY UH, State DOE, Private Schools
	LEAD AGENCY(IES) Native Hawaiian Agencies, DOE, UH, HSI
2.8 That all efforts be made to speed up the availability of lands for Native Hawaiians to which Native Hawaiians have legal claims.	TARGET AGENCY State Judiciary, DHHL, DLNR
	POTENTIAL RESOURCES Judiciary
	LEAD AGENCY(IES) Native Hawaiian Agencies, OHA, DHHL, NHL

2.9 That social epidemiology studies focusing on family, work, and community expectations, performance, and adjustment of Native Hawaiians be conducted.	TARGET AGENCY UH, State DOH
	POTENTIAL RESOURCES NIMH
	LEAD AGENCY(IES) Native Hawaiian Agencies, HSI
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2.10 That research be done on community leadership development and natural support systems in the Native Hawaiian community.	TARGET AGENCY UH, State DSSH
	POTENTIAL RESOURCES OHA
	LEAD AGENCY(IES) Native Hawaiian Agencies, HSI
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2.11 That research be done on Native Hawaiian healers.	TARGET AGENCY UH, State DSSH, State DOH
	POTENTIAL RESOURCES NIMH
	LEAD AGENCY(IES) Native Hawaiian Agencies, HSI
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2.12 That a survey be conducted on service delivery and options and preferences for mental health services in the Native Hawaiian community.	TARGET AGENCY State DOH
	POTENTIAL RESOURCES NIH, NIMH
	LEAD AGENCY(IES) Native Hawaiian Agencies
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2.13 That Hawaiian language materials be translated to better understand Native Hawaiian health, history, culture, and values.	TARGET AGENCY State DOE, UH, Legislature, Private Sectors
	POTENTIAL RESOURCES OHA
	LEAD AGENCY(IES) OHA, KS/BE, HSI

2.14 That there be developed ethnic identity scales which measure conformity to a range of lifestyles.

TARGET AGENCY
UH, State DOH

POTENTIAL RESOURCES
NIMH

LEAD AGENCY(IES)
Native Hawaiian Agencies

2.15 That there be supported and conducted research to continually assess prevalence and incidence of alcohol and drug abuse as well as environmental health problems among Native Hawaiians and in predominantly Native Hawaiian communities and to study the mental health related risk factors and hazards in the social and physical environments.

TARGET AGENCY
UH, State DOH, Health Care Organizations

POTENTIAL RESOURCES
State DOH, EPA, NIMH, NIH, DHHS, DOT, UH

LEAD AGENCY(IES)
State DOH, Native Hawaiian Agencies

2.16 That federal programs focusing on mental health be made accessible for Native Hawaiians and responsive to Native Hawaiian needs.

TARGET AGENCY
DHHS, Congress

POTENTIAL RESOURCES
OHDS, PHS, ADAMHA, CDC, HRA, HSA, NIH, HCFA

LEAD AGENCY(IES)
Native Hawaiian Agencies, State DOH

3.0 MEDICAL

3.1 That the State of Hawaii allocate its health resources to give priority to Native Hawaiian health problems.

TARGET AGENCY
Legislature, State DOH

POTENTIAL RESOURCES
State DOH

LEAD AGENCY(IES)
State DOH

3.2 That existing health care organizations include qualified Native Hawaiians on their boards.

TARGET AGENCY
Community Health Care Organizations

LEAD AGENCY(IES)
Community Health Care Organizations

3.3 That an umbrella body for monitoring and planning for Native Hawaiian health needs be established.	TARGET AGENCY Native Hawaiian Community
	POTENTIAL RESOURCES HSIA, OHA, DHHS
	LEAD AGENCY(IES) Native Hawaiian Agencies
3.4 That Native Hawaiian parity in the health professions be targeted through scholarship programs and academic monitoring and support.	TARGET AGENCY UH, KS/BE, Private Foundations
	POTENTIAL RESOURCES KS/BE, UH-SOM, OHA
	LEAD AGENCY(IES) KS/BE
3.5 That a system of Native Hawaiian community health workers be developed to provide outreach services on behalf of health care programs serving Native Hawaiians, including health education, screening, referral, and follow-up care.	TARGET AGENCY Health Care Organizations, State DOH
	POTENTIAL RESOURCES National Center for Disease Control, Native Hawaiian Organizations
	LEAD AGENCY(IES) Native Hawaiian Organizations
3.6 That health education, screening and health promotion programs be provided through community groups having high Native Hawaiian membership.	TARGET AGENCY Health Care Organizations, State DOH
	POTENTIAL RESOURCES HSIA, Native Hawaiian Organizations, KS/BE, Health Care Organizations
	LEAD AGENCY(IES) Health Care Organizations
3.7 That active outreach efforts be incorporated into every major health center in Honolulu and into clinics serving rural Native Hawaiian populations, using Native Hawaiian community health workers.	TARGET AGENCY Health Care Organizations, State DOH
	POTENTIAL RESOURCES Health Care Organizations, State DOH
	LEAD AGENCY(IES) Health Care Organizations

<p>3.8 That a review be undertaken of health care programs, such as Queens Hospital and Lunalilo Home, which were established to provide care for Native Hawaiians, in order to determine whether or not these organizations are fulfilling their obligations.</p>	<p>TARGET AGENCY OHA, Judiciary, Queens Hospital, Lunalilo Home, Kapiolani Hospital</p>
	<p>POTENTIAL RESOURCES OHA, HSIA, Lunalilo Home, Queens Hospital, Kapiolani Hospital</p>
	<p>LEAD AGENCY(IES) OHA</p>
<p>3.9 That Hawaiian cause organizations undertake self-reviews of level and scope of effort in provision of health and medical services, development of culturally useful and valid materials and curriculum for health education, promotion, and prevention, and follow-up work on surveillance and risk reduction evaluations.</p>	<p>TARGET AGENCY Hawaiian Organizations</p>
	<p>POTENTIAL RESOURCES Native Hawaiian Organizations</p>
	<p>LEAD AGENCY(IES) Native Hawaiian Organizations</p>
<p>3.10 That a cultural training program be developed for physicians working in Hawaii regarding traditional Hawaiian beliefs, attitudes and practices of health care.</p>	<p>TARGET AGENCY Health Care Organizations, State DOH</p>
	<p>POTENTIAL RESOURCES KS/BE, HSIA, HSI</p>
	<p>LEAD AGENCY(IES) Health Care Organizations</p>
<p>3.11 That health care providers be educated about Hawaiian styles of seeking help and relating to others and that modes of service delivery be developed which are culturally compatible with Hawaiian culture.</p>	<p>TARGET AGENCY Health Care Organizations, State DOH</p>
	<p>POTENTIAL RESOURCES KS/BE, HSIA, HSI</p>
	<p>LEAD AGENCY(IES) Health Care Organizations</p>

<p>3.12 That cooperation be fostered between traditional Hawaiian healers and physicians, perhaps using community health workers as a bridge, in order that the health needs of Hawaiians can be more effectively served by both.</p>	<p>TARGET AGENCY Health Care Organizations</p> <p>POTENTIAL RESOURCES ALU LIKE, OHA, KS/BE, HSI</p> <p>LEAD AGENCY(IES) Health Care Organizations</p>
<p>3.13 That traditional Hawaiian remedies be incorporated into the care of Native Hawaiians whenever medically feasible.</p>	<p>TARGET AGENCY Health Care Organizations</p> <p>POTENTIAL RESOURCES ALU LIKE, OHA, KS/BE, HSI</p> <p>LEAD AGENCY(IES) Health Care Organizations</p>
<p>3.14 That in matters of health research, surveillance, and evaluation of health education, prevention, promotion, and services, talented Native Hawaiians be involved in opportunities for research training, research participation and dissemination and utilization of valid and useful findings and recommendations.</p>	<p>TARGET AGENCY State DOH, UH Health Care Organizations</p> <p>POTENTIAL RESOURCES KS/BE, ALU LIKE, HSI, State DOH, State DOE, UH</p> <p>LEAD AGENCY(IES) State DOH, UH, Health Care Organizations</p>
<p>3.15 That family planning services be maintained to promote family planning consistent with the health needs of parents and children.</p>	<p>TARGET AGENCY Health Care Organizations, Planned Parenthood</p> <p>POTENTIAL RESOURCES KS/BE, ALU LIKE, Planned Parenthood</p> <p>LEAD AGENCY(IES) Health Care Organizations</p>
<p>3.16 That the statewide perinatal health care system specifically focus on the Native Hawaiian need for education regarding the risk factors associated with congenital anomalies and low birth weight, breast-feeding, and parenting behaviors.</p>	<p>TARGET AGENCY Health Care Organizations, State DOE</p> <p>POTENTIAL RESOURCES KS/BE, ALU LIKE, Health Care Organizations</p> <p>LEAD AGENCY(IES) Health Care Organizations</p>

3.17 That health promotion program and health screening be provided through established social networks, such as churches, civic clubs, canoe clubs and other community organizations having a high Native Hawaiian membership.

TARGET AGENCY
Health Care Organizations

POTENTIAL RESOURCES
Health Care Organizations,
Native Hawaiian Organizations

LEAD AGENCY(IES)
Health Care Organizations,
State DOH

3.18 That screening programs for Native Hawaiians include systematic referral and follow-up, using Native Hawaiian community health workers.

TARGET AGENCY
Health Care Organizations

POTENTIAL RESOURCES
KS/BE, ALU LIKE,
Health Care Organizations

LEAD AGENCY(IES)
Health Care Organizations
State DOH

3.19 That health care organizations serving Native Hawaiian communities, especially in rural areas, develop programs which integrate Western and traditional Hawaiian approaches to health care and medical treatment.

TARGET AGENCY
Health Care Organizations

POTENTIAL RESOURCES
KS/BE, HSIA, HSI,
Native Hawaiian Organizations

LEAD AGENCY(IES)
Health Care Organizations

3.20 That more resources be provided to public schools to implement a comprehensive health education curriculum.

TARGET AGENCY
State DOE

POTENTIAL RESOURCES
KS/BE, HSI, State DOH,
NIMH, U.S. DOE, Legislature

LEAD AGENCY(IES)
State DOE

3.21 That a fund be established by the State of Hawaii to provide medical care for medically indigent persons without medical insurance and who do not qualify for Medicare or Medicaid programs.

TARGET AGENCY
Legislature, State DOE

POTENTIAL RESOURCES
HSIA, Private Sector

LEAD AGENCY(IES)
State DOH, State DSSH

3.22 That the state initiate measures to solve the malpractice insurance crisis which impacts especially on the availability of medical care in rural areas where many Native Hawaiians reside.	<p>TARGET AGENCY Legislature</p> <p>POTENTIAL RESOURCES Health Care Organizations, Physicians</p> <p>LEAD AGENCY(IES) Health Care Organizations</p>
3.23 That health promotion programs with a Hawaiian cultural component be developed to focus on life style changes, including alcohol abuse, tobacco and drug abuse, obesity, nutrition, and stress-management.	<p>TARGET AGENCY State DOE, Private Schools</p> <p>POTENTIAL RESOURCES State DOH, NIMH, DHHS</p> <p>LEAD AGENCY(IES) Native Hawaiian Organizations</p>
3.24 That state support be provided to agencies providing health education programs and screening and referral programs for Native Hawaiians, especially in regard to cancer, diabetes, hypertension, and pre-natal and early infant care.	<p>TARGET AGENCY Legislature, State DOH</p> <p>POTENTIAL RESOURCES ALU LIKE, KS/BE, HSI, OHA</p> <p>LEAD AGENCY(IES) Native Hawaiian Organizations</p>
3.25 That support be given to developing preventive and screening programs for cancers in Native Hawaiians.	<p>TARGET AGENCY Legislature, State DOH, Cancer Center</p> <p>POTENTIAL RESOURCES Cancer Center, ALU LIKE, KS/BE, OHA, Health Care Organizations</p> <p>LEAD AGENCY(IES) Native Hawaiian Organizations</p>
3.26 That statewide screening programs for diabetes and hypertension be modified to target the Native Hawaiian population.	<p>TARGET AGENCY Legislature, State DOH</p> <p>POTENTIAL RESOURCES Health Care Organizations, ALU LIKE, KS/BE, OHA</p> <p>LEAD AGENCY(IES) Native Hawaiian Organizations</p>

3.27 That ongoing health surveillance of the Native Hawaiians be continued and expanded in order to determine trends in health status and current needs for health care programs.

TARGET AGENCY
State DOH

POTENTIAL RESOURCES
Health Care Organizations,
Native Hawaiian Organizations

LEAD AGENCY(IES)
State DOH

3.28 That utilization data be systematically collected by all health programs and organizations in order to be able to determine the extent to which Native Hawaiians are receiving health services.

TARGET AGENCY
Health Care Organizations,
State DOH

POTENTIAL RESOURCES
Health Care Organizations,
Native Hawaiian Organizations

LEAD AGENCY(IES)
State DOH

3.29 That research be undertaken to focus on the level of health knowledge, attitudes towards health services, and cultural values which affect participating in health programs and using medical services.

TARGET AGENCY
Health Care Organizations,
State DOH

POTENTIAL RESOURCES
Native Hawaiian Organizations

LEAD AGENCY(IES)
Native Hawaiian Organizations,
UH, State DOH

3.30 That evaluation studies be done of all programs which target Native Hawaiians in order to ascertain their effectiveness.

TARGET AGENCY
Health Care Organizations,
State DOH

POTENTIAL RESOURCES
Native Hawaiian Organizations,
UH

LEAD AGENCY(IES)
Health Care Organizations,
State DOH

3.31 That additional research be undertaken to investigate the etiological factors which account for higher disease rates among Native Hawaiians, such as higher rates of birth abnormalities, diabetes, hypertension, heart disease and cancer.

TARGET AGENCY
Health Care Organizations,
Researchers, State DOH

POTENTIAL RESOURCES
Native Hawaiian Organizations

LEAD AGENCY(IES)
Health Care Organizations,
State DOH

3.32 That additional research be undertaken to assess the prevalence and incidence of socio-environmental health problems among Native Hawaiians, including possibly greater exposure to pesticides, occupational hazards, social stress, and other noxious social and physical conditions.

TARGET AGENCY
Health Care Organizations,
Researchers, State DOH

POTENTIAL RESOURCES
Native Hawaiian Organizations

LEAD AGENCY(IES)
Health Care Organizations,
State DOH

3.33 That federal programs focusing on medical health be made accessible to Native Hawaiians and responsive to Native Hawaiian needs.

TARGET AGENCY
DHHS, Congress

POTENTIAL RESOURCES
OHDS, PHS, ADAMHA,
CDC, HRA, HSA, NIH, HCFA

LEAD AGENCY(IES)
Native Hawaiian Agencies,
State DOH

4.0 NUTRITION AND DENTAL HEALTH

4.1 That there be developed programs in the Native Hawaiian community promoting breast-feeding.

TARGET AGENCY
State DOH, Community
Health Organizations

POTENTIAL RESOURCES
State DOH, State DHHS

LEAD AGENCY(IES)
State DOH

4.2 That there be developed additional nutritional programs for Native Hawaiians focusing on child nutrition.	<p>TARGET AGENCY State DOH, Community Health Organizations</p>
	<p>POTENTIAL RESOURCES State DOH, State DHHS</p>
	<p>LEAD AGENCY(IES) State DOH</p>
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4.3 That there be developed additional nutritional education programs for Native Hawaiians focusing on families and children.	<p>TARGET AGENCY State DOH</p>
	<p>POTENTIAL RESOURCES State DOH, State DHHS, KS/BE</p>
	<p>LEAD AGENCY(IES) State DOH, State DOE</p>
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4.4 That there be developed culturally-sensitive educational programs for Native Hawaiian children in elementary and secondary school.	<p>TARGET AGENCY State DOE, Private Schools</p>
	<p>POTENTIAL RESOURCES KS/BE, State DOH</p>
	<p>LEAD AGENCY(IES) State DOE, Private Schools</p>
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4.5 That there be additional nutrition research on all aspects of diet and health promotion including alcohol and drug abuse as these affect Native Hawaiians and members of the total Hawai'i community.	<p>TARGET AGENCY State DOH, UH</p>
	<p>POTENTIAL RESOURCES State DOH, State DHHS</p>
	<p>LEAD AGENCY(IES) State DOH</p>
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4.6 That there be nutritional surveillance and monitoring of diets and health promotion of Native Hawaiians and other ethnic groups in Hawai'i.	<p>TARGET AGENCY State DOH</p>
	<p>POTENTIAL RESOURCES State DOH, State DHHS</p>
	<p>LEAD AGENCY(IES) State DOH</p>

4.7 That there be a provision and promotion of traditional Native Hawaiian food resources.	<p>TARGET AGENCY Community at Large, State DOH</p> <p>POTENTIAL RESOURCES State Legislators, State Department of Land and Natural Resources</p> <p>LEAD AGENCY(IES) State DOH, State DOE</p>
4.8 That there be positive efforts made to fluoridate Hawaii’s water system.	<p>TARGET AGENCY Legislature, State DOH</p> <p>POTENTIAL RESOURCES State DOH, Legislature</p> <p>LEAD AGENCY(IES) State DOH</p>
4.9 That there be provision for Native Hawaiians without dental insurance to receive needed dental care and treatment.	<p>TARGET AGENCY Legislature, State DSSH</p> <p>POTENTIAL RESOURCES State DOH</p> <p>LEAD AGENCY(IES) State DOH</p>
4.10 That there be additional dental educational programs targeted at Native Hawaiians and their families.	<p>TARGET AGENCY State DOH</p> <p>POTENTIAL RESOURCES State DOH, State DOE, KS/BE</p> <p>LEAD AGENCY(IES) State DOH, State DOE</p>
4.11 That there be additional school-based dental education and hygiene programs.	<p>TARGET AGENCY State DOE, Private Schools,</p> <p>POTENTIAL RESOURCES State DOH, State DOE, KS/BE</p> <p>LEAD AGENCY(IES) State DOH, State DOE</p>

4.12 That there be a culturally sensitive training program developed for teachers and dental health professionals.	TARGET AGENCY State DOE, Private Schools, UH
	POTENTIAL RESOURCES KS/BE, HSI, UH
	LEAD AGENCY(IES) State DOH, State DOE
4.13 That there be a continuous effort to protect youngsters against dental injuries in competitive sports.	TARGET AGENCY Community at Large
	POTENTIAL RESOURCES State DOH, Private Dentists
	LEAD AGENCY(IES) State DOH, State DOE
4.14 That there be a systematic and on-going survey for dental data as it relates to Native Hawaiians and to the general public.	TARGET AGENCY State DOH
	POTENTIAL RESOURCES State DOH
	LEAD AGENCY(IES) State DOH
4.15 That there be supported and conducted research to continually assess prevalence and incidence of environmental health problems among Native Hawaiians and in predominantly Native Hawaiian communities and to study the nutritional and dental risk factors and hazards in the social and physical environments.	TARGET AGENCY State DOH
	POTENTIAL RESOURCES State DOH, EPA, NIMH, NIH, State DHHS, DOT, UH
	LEAD AGENCY(IES) State DOH, Native Hawaiian Agencies
4.16 That federal programs focusing on nutrition and dental health be made accessible to Native Hawaiians and responsive to Native Hawaiian needs.	TARGET AGENCY DHHS, Congress
	POTENTIAL RESOURCES OHDS, PHS, ADAMHA, CDC, HRA, HSA, NIH, HCFA
	LEAD AGENCY(IES) Native Hawaiian Agencies, State DOH

B. MODELS FOR NATIVE HAWAIIAN HEALTH

1. Levels of Responsibility

Responding to the identified health needs of Native Hawaiians is not the sole responsibility of any one agency, group, or level of government. It is a shared responsibility requiring the participation of the Native Hawaiian community, the state's private sector, and the state and federal governments acting as initiators and catalysts for health improvement.

a. Native Hawaiian Community

Native Hawaiian communities exist both as statewide networks and as individual local communities. Planning, implementing and monitoring of health programs addressing Native Hawaiian needs are the responsibility of the Native Hawaiians themselves provided they are given appropriate authority, training, and support.

Local communities should play a major role in providing for the delivery of health services to Native Hawaiians. Communities that are composed predominately of Native Hawaiians often have existing networks through clubs, churches, service organizations, and agencies that interact to create informal communication systems and channels for assistance. Funding for programs impacting on Native Hawaiian health must reach to these networks, and participation of these networks in overall program planning, managing, and monitoring must be encouraged.

b. Hawaii's Private Sector

The state's business and organized labor communities also must participate in and support Native Hawaiian health initiatives on a statewide basis and at the local community level. This can be done through participation on local agency and community-based organization's boards and advisory groups.

Hawai'i's health professional organizations including the Hawai'i Medical Association and the Hawai'i Dental Society must be included in efforts to address Native Hawaiian health concerns. Their support is essential for the development of new and innovative programs which could include designating "health manpower shortage areas" in the state based on population group needs, underserved ethnic groups, and socio-economic indicators, rather than physician to general population ratio. Other Native American groups have health programs based on such criteria.

c. The Public Sector

The State of Hawai'i is in a pivotal position to improve the quality of Native Hawaiian health. The Department of Health administers federal block grant health monies and provides for surveillance of the state population's health status. The State Health Planning and Development Agency is responsible for health planning, which should include conducting and maintaining health needs assessments of Hawai'i's ethnic groups and geographic sub-areas. The Department of Social Services and Housing administers the state Medicaid and Medicare programs and sets the rules by which those serving low-income populations can receive reimbursement for health services rendered. It is the position of this Study that, whenever possible, existing delivery systems for health care and related services be used to support Native Hawaiian health programs. It is incumbent upon the State, however, to review and evaluate its current health delivery system as it addresses Native Hawaiian health concerns. This will be particularly important if additional resources are to be made available for Native Hawaiian health and the State were to participate in implementing a process for the dispersal of those resources.

As has been noted earlier in this plan, both the state and federal governments have a shared responsibility in assuring proper availability of health resources for Native Hawaiians. The federal role stems from its political and social relationships with Native Hawaiians and other Native American groups. In terms of this Plan's emphasis on the need for additional health resources for Native Hawaiians, the federal role is essential and complements that of the state. Its primary focus should be on unmet health needs of Native Hawaiians and how best to provide resources to address those needs through existing channels of federal support which can link with the Native Hawaiian community to provide "pathways for progress" and improved Native Hawaiian health.

2. Relationship to Federal Health Policy

The special relationship between the federal government and Native Hawaiians already has been discussed. It also is important to demonstrate the relationship between the findings and recommendations of this Study and the national health policy.

The Reagan Administration has adopted health policy guidelines developed by the U.S. Surgeon General over a period of years and articulated in *Healthy People: The Surgeon-General's Report on Health Promotion and Disease Prevention and Objectives for the Nation*. The basic assumption behind the guidelines for health policy is that, by improving health services and resources and activities, there will be increased public and professional awareness of health issues. Increased awareness, in turn, will reduce identified risk factors which will lead to improved health status. Green, Wilson, and Bauer (1983) have depicted clearly some of the programmatic relationships suggested by the U.S. Surgeon General's Report (see Figure 3).

In reality, relationships as they are impacted by different social forces are not solely linear. Increased public and professional awareness may predispose, enable, and reinforce which, in turn, may lead directly to improved access and environmental change. Such activity also may cause resources to be organized or environments to be regulated. This approach applies equally to groups such as families or other social groupings. In order to show how the results of this Study may be interpreted in the perspective of federal policy, the Consortium has placed its health recommendations within the context of the federal model (see Figure 4). The majority of recommendations made by this Study fall within the area of "organizing resources" or "predisposing, enabling, or reinforcing."

3. In Keeping With Local Initiatives

Several health-related models have been proposed or are being developed locally which have demonstrated effectiveness either in the Native Hawaiian community or in the community at large and through which many of this Study's recommendations can be addressed. Together, these models provide an integrated system for primary health service delivery to Native Hawaiians. The six component models which compose that system include:

- a. Health planning and monitoring component
- b. Traditional Native Hawaiian practice health component
- c. Health research and surveillance component
- d. Professional health training component
- e. Health promotion component
- f. Primary health care component

The factors affecting Native Hawaiian health are complex. Solutions to the problems and concerns identified in this Study will be equally complex. Only by developing and encouraging a systematic and comprehensive approach to address these problems and concerns will any lasting impact be realized. That impact can best be achieved through an integrated system for primary health care and service delivery focusing on identifying Native Hawaiian health problems. The components of that system include:

a. Health Planning and Monitoring Component

Native Hawaiians should have influence over programs specifically designed to address their needs. As has been the experience with other federal programs for Native Hawaiians, health programs should be planned, implemented, and developed by the Native Hawaiian community itself. Monitoring of federal dollars flowing into the Native Hawaiian community should also be a responsibility of that community.

For these reasons, there needs to be established or designated a Native Hawaiian health planning entity which can serve as the planning, development, and monitoring agency for Native Hawaiian health. As previously stated, this can best be done by the Native Hawaiian community itself. There are several organizations in place which could serve as this entity. ALU LIKE has served this function well for Native Hawaiian social research and employment and training programs and is presently coordinating the Native Hawaiian Health Research Consortium which is conducting this Study. Other organizations within the Hawaiian Service Institutions and Agencies (HSIA) or the Office of Hawaiian Affairs also may be interested as serving in this capacity.

b. Traditional Native Hawaiian Health Component

Practitioners of traditional Native Hawaiian medicine still play an important role in the lives of many Native Hawaiians. There needs to be an understanding of this among health planners and policy-makers. For many individuals, traditional medical treatment is primary and the one first sought. By providing and strengthening a program for these individuals and legitimizing traditional medicine in those instances where it is appropriate, the integration of Western medical practices with those of traditional medicine can be accomplished.

This integration may be informal networking between physicians and nurses and traditional healers, or kahuna, or it may involve more formal arrangements, such as patient referral or joint treatment. Whatever the outcomes, the advantage of having a recognized traditional health component is that it strengthens the overall health system and provides for mutual educational experiences between western and traditional health professionals. Hale Ola Ho'opākōlea, a private, nonprofit organization in Nanakuli, provides counseling and appropriate medical treatment in the traditional Native Hawaiian manner (see description in Part VI). Additional resources are needed to support this type of activity.

c. Health Research and Surveillance Component

Understanding more about the health needs of Native Hawaiians and the effectiveness of systems that interact with them is essential. It should be noted that research data in this report were acquired with considerable difficulty. In order to provide a sufficient research base for future health policy and programs regarding Native Hawaiian health, continuing and expanded research is needed. Competitive research grants directly funded to individuals and/or agencies could support such efforts.

The efforts of this Consortium in developing this Study indicate what can be accomplished in a coordinated, focused manner in terms of research activity. It is proposed that a coordinated, broad-based, research-oriented group similar to that of the Native Hawaiian Health Consortium be constituted to oversee research efforts in the Native Hawaiian community. Such efforts must be sensitive and responsive to Native Hawaiian culture and should attempt to build competencies through training within the Native Hawaiian community itself. It should also involve Native Hawaiians in defining research issues, developing research designs, and in carrying out the actual research activities. It is also important that the results of research activities be reported back to the community for review, comment, and revision.

Monitoring the health status of Native Hawaiians through health surveillance and data-collection that targets specific health status indicators and provides data linkage between primary care providers and those concerned with health planning and evaluation are crucial for any integrated system.

Presently, collection of health data is done primarily by the Hawaii State Department of Health and its current Health Surveillance Program. Financial constraints dictate that most reporting currently is done within the county matrix rather than the community matrix. This often makes it difficult to isolate Native Hawaiian data. However, independent health surveillance activity has been undertaken by a few private and public agencies to produce Native Hawaiian data.

If Native Hawaiian health surveillance could be developed, it would work closely with research and the other components of the system. The opportunity to solicit proposals from a variety of groups, including the State Department of Health, to establish a Native Hawaiian health data base is an exciting idea and one which needs to be realized.

d. Professional Health Training Component

For effective community health, it is essential to have health care services delivered by members of that community. Native Hawaiians are under-represented in the health care professions. Development of Native Hawaiian health professionals and workers at all levels is an essential factor in improving the health status of Native Hawaiians.

Currently the University of Hawaii's School of Public Health and Medicine have programs for training minorities in the health professions. (See "Imi Ho'ola" description in Part VI). In addition The Kamehameha Schools/Bernice P. Bishop Estate offers two scholarship programs for Native Hawaiians which could be utilized by those seeking careers in the health professions. The first, Nā Ho'okama is for undergraduate education while the second, Nā Poki'i, is for graduate school education (see descriptions in Part VI). Targeting programs such as these for support would be desirable and could impact considerably in fostering Native Hawaiians to achieve parity with other ethnic groups in the health professions.

Work Study programs and summer youth programs in community clinics and hospitals can also be effective in offering young Native Hawaiians early experiences in health care environments.

e. Health Promotion Component

Health promotion is health education. Many health education programs are based on behavior modification and/or changing environmental factors that influence disease. Unfortunately many environmental factors are beyond the power of individual or current community commitment. Some of the identified environmental factors impacting on Native Hawaiian health include –

- Erosion of native cultural identity and alienation from the dominant non-native culture;
- Increased crowding, traffic, and noises;
- Environmental pollution through deteriorating air quality, water quality, and possible electromagnetic radiation;

Poor quality housing and the lack of affordable housing;

- Inability of many schools to meet the individual educational needs of youngsters; and
- General lack of concerted control over environmental change, community growth, and patterns of development.

These factors are contributors to stress, risk-taking, and alienation.

The Federal Government, through the Public Health Service, has developed block grant or categorical grant programs to target many of these high-risk preventable health problems. These programs include maternal and child health, immunization programs, health prevention programs, venereal disease programs, and vocational rehabilitation.

Most of the resources associated with these programs currently are absorbed by the Hawai'i State Department of Health which maintains policy of cultural and ethnic neutrality. Programs and resources are not targeted to any particular ethnic group. This policy greatly lessens the potential impact of such programs on the Native Hawaiian community.

An augmentation to these preventive health monies flowing directly to community-based organizations could have a profound impact. It is important to note that such federal grant programs on the U.S. mainland are often, if not always, channeled to community agencies. Several of acceptable and successful disease prevention and health promotion models exist locally. Two which have a particular application to the Native Hawaiian community are Mālama Ola at the Waianae Coast Comprehensive Health Center and The Kamehameha School's Parent Child Development Centers (see descriptions in Part VI).

f. Primary Health Care Component

Appropriate health care is the end result of health services provided through an acceptable system. That system must incorporate traditional health concepts and values, eliminate financial barriers to service delivery, provide qualified and culturally sensitive medical personnel capable of communicating effectively, and instill a sense of "ownership" in those using the system.

The community health center model (Sec. 330 PHS Act) seems well suited for providing primary health care to Native Hawaiians. Policy governing the operation of each center is developed by a community-based board, representative of the community. Currently there are more than 600 community health centers operating throughout the United States with two in Hawai'i, one serving a predominantly Native Hawaiian community.

Elsewhere in the Pacific, the community health center model is being encouraged by policy-makers and health professionals. Some of the areas currently developing or considering community health care centers are Guam, Commonwealth of the Northern Mariana Islands, Republic of Palau, Federated States of Micronesia, and Republic of the Marshall Islands.

Besides being community based, community health centers generally provide a broad scope of services with preventive health initiatives, immunization programs, outreach programs and other health promotion programs.

The inclusion of a community outreach capacity based on the district nurse/community health representative model is important. In Pacific Island communities and in Native American communities on the mainland United States, a primary ingredient of successful health programs has been the ability of outreach programs to impact on individual households.

Outreach health professionals serve as vehicles for health protection and disease prevention through direct intervention and health education.

Funding levels are often dependent upon performance indicators ascertained from the various components of health programs stemming from primary health care centers. In addition, these centers follow a structured system of quality assurance and performance reporting requirements as directed by the Bureau of Common Reporting Requirements. Precise documentation is required for all primary health care activity.

While community health care centers should not be the only system for providing primary health care to Native Hawaiians, they offer a viable model for service delivery. The two existing centers in the State are the Wai'anae Coast Comprehensive Health Care Center and the Kōkua Kalihi Valley Community Health Care Center.

It is important to emphasize the integration of health services to Native Hawaiians when reviewing health models. The components must all work as closely together as the crew of a traditional Hawaiian outrigger canoe (see Figure 5). Planning, monitoring, and surveillance are closely related to the steering and guiding functions while culture and tradition set the pace for the entire canoe.

In conclusion, any resources directed at Native Hawaiian health needs should truly be felt by Native Hawaiian peoples. To accomplish this, emphasis has to be placed on direct services to Native Hawaiians within the framework of an integrated system or approach.



Part III | A Strategy for Improved Hawaiian Health

III. A strategy for improved Native Hawaiian health

Improved Native Hawaiian health can be a reality. The findings and recommendations of this Study are geared to that happening. It is important to keep in mind, however, that before this can occur there needs to be a commitment made on behalf of government at the federal and state levels and on behalf of Native Hawaiians at the community level to make this happen.

This Study is but the first step. It is preliminary in its findings, but the existing data indicate that Native Hawaiians have health concerns and problems more severe than other groups in the State of Hawai'i and, because of the unique and special relationship which Native Hawaiians continuously have had with the Federal Government, first as citizens of a sovereign nation and more recently as Native Americans, it is appropriate that the Federal Government assist.

The recommendations of this Study generally are directed at the federal, state, and community levels of political organization. If they are to be realized, several actions have to occur at all three levels. At the federal level there will be a need to introduce and/or amend legislation for Native Hawaiian health initiatives. Also, there continues to be a need to network and to compete more actively for existing resources both at the regional and national levels. At the state level there is a need for public policy makers and government leaders to support Native Hawaiian health initiatives and to begin a concerted effort to build Native Hawaiian coalitions around health issues and to form an integrated system for addressing Native Hawaiian health concerns and problems. At the community level, there is a need to focus on training Native Hawaiian health professionals who are culturally sensitive, themselves, and who can impart upon non-Native Hawaiian those values which are necessary for understanding. In addition, it is important that Native Hawaiians assume leadership roles in regards to health planning and program development.

While all these actions are vital to realizing this Study's recommendations, there currently is no duly recognized Native Hawaiian group or organization to initiate change where change is needed or to marshal resources where resources are available in regards to health.

It is proposed, therefore, that a Native Hawaiian Health Planning Advisory Committee be formed. Members of the Committee should represent organizations primarily serving and representing Native Hawaiians and organizations concerned with health service delivery and education. This Committee will work closely with the U.S. Department of Health and Human Services to encourage the development of a Native Hawaiian initiative to improve Native Hawaiian health. The responsibility of the Committee will be to develop strategies at the federal, state, and community levels for improving Native Hawaiian health. The Committee will also designate a lead agency to oversee planning for future programs focusing on Native Hawaiian health and to begin monitoring and evaluating progress in implementing this Study's recommendations. A precedent for this was established by Hawai'i's Governor when he constituted the Native Hawaiian Advisory Panel for Native Hawaiian programs under the Carl D. Perkins Vocational Education Act and the Library and Construction Act.

Finally, this Study recommends that the Department of Health and Human Services, through its resources, assist the designated lead agency in establishing an integrated health service delivery system for Native Hawaiians.

That delivery system must be appropriate in terms of accessibility, availability, and acceptability. All new programs must take into consideration what it is that they are replacing or developing, and they must be easily implemented, continuous, and supported by the existing social structure. In addition, these programs must explore ways of integrating, where possible, traditional Hawaiian culture and modern medicine to insure Native Hawaiian acceptability. They must be cost effective yet be able to make real socio-economic impact as they relate to the health of Native Hawaiians. Finally, such programs must be cognizant of the efforts of community groups and organizations and, whenever possible, attempt to work through and in conjunction with such groups and organizations and be responsive to community needs and problems.

The recommendations in this Study are not objectives: they are indicators of need. It will be necessary to translate these indicators into quantifiable objectives and to then pursue each and to marshal resources where and when appropriate. It is in this effort that a real partnership needs to be developed between Native Hawaiians and the public and private sectors in a concerted effort to improve Native Hawaiian health in ways that Native Hawaiians, themselves, define. It will be only through such action that rehabilitation in its truest sense reflecting restored health and vitality will be realized.

LOA' A KE OLA I HALAU A OLA
(Gain health by learning health)



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