

Papa Ola Lōkahi

E OLA MAU A MAU

THE NEXT GENERATION OF NATIVE HAWAIIAN HEALTH

INTRODUCTION

E OLA MAU A MAU – THE NEXT GENERATION OF NATIVE HAWAIIAN HEALTH

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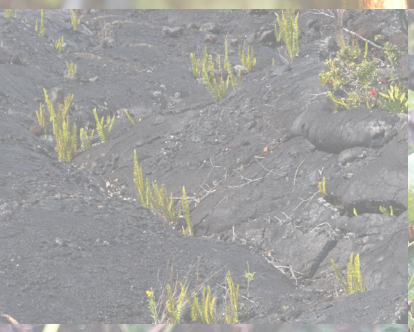
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Introduction

Introduction

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Kānaka Maoli: the indigenous, first nations people of Ko Hawaiʻi Pae ʻĀina, the Hawaiian Islands. As indicated by *E Ola Mau – The Native Hawaiian Health Needs Study* (*E Ola Mau*) of 1985, the overall health and social determinants of health for Native Hawaiians reflect disparities that place Native Hawaiians near or at the top of risk for poor health and wellness outcomes. However, as will be made evident by this *E Ola Mau a Mau* of 2019, Native Hawaiians continue to defy the odds. Native Hawaiian communities have eked out pockets of success where the health and vibrancy of their infants, children, youth, parents, adults, elders, and families have been achieved. Building upon this track record of gains, the goal of the efforts generating this report is to join these successes into distinct and complementary components of a system of health care that educates, inspires, supports, and focuses every Native Hawaiian to become an engaged participant in his or her health and wellness. The findings and recommendations of this 2019 *E Ola Mau a Mau* will be used to guide future efforts as well to support the reauthorization of the Native Hawaiian Health Care Law by Hawaii's congressional delegation.

Historical Background

Native Hawaiians are the only indigenous people in the United States whose congressional legislative health care policy (Public Law 100-579; 20 l Stat. 2916) lacks a permanent authorization of appropriations. After 30 years—an entire generation—of implementing the Native Hawaiian Health Care Law, this new report, *E Ola Mau a Mau,* updates the original 1985 report.

The 1988 Native Hawaiian Health Care Improvement Act has brought an average of approximately $9 million per year into Hawaiʻi to serve over 200,000 Hawaiians. That amounts to less than $45 per person, per year. Compare that to the $9,403 – $9,892 range per person, per year that the United States spent on health in 2017 (Organization for Economic Cooperation and Development [OECD], 2017; Papanicolas, Woskie & Jha, 2018), or to the $9,726[1] per American Indian/Alaskan Native per year (Indian Health Service, 2019). Focusing specifically on users of the Native Hawaiian Health Care System clinical/health care services, about 25,000 men, women, and children are users (Papa Ola Lōkahi, 2018). Therefore, the estimated cost per user is $360 per person/year. Compare this to the $4,078 per person, per year that the Indian Health Service spends on American Indian/Alaskan Native users (Indian Health Service, 2019). The annual allocations for Native Hawaiians received from the federal government, while deeply appreciated, have not been enough to generate the critical mass of energy and momentum to enable Native Hawaiian health care leaders to successfully execute the master health plan set forth by Papa Ola Lōkahi, the Native Hawaiian Health Board.

Because of the insufficiency in resources, the outcomes of this legislation have been mixed. The *E Ola Mau* report of 1985 was the first time that a concerted, comprehensive effort was made to document the health status of Native Hawaiians. The results were alarming. Some scientists predicted that Native Hawaiians would become extinct because of Native Hawaiian morbidity and mortality rates (Goo, 2015). However, the Office of Hawaiian Affairs, Research Division Demography (2017) report noted that the Native Hawaiian population in Hawaiʻi increased from 239,655 to 289,970 in the years between 2000 and 2010.

Gains in the sciences and scholarship have been made with over 140,000 publications (2018 Google Scholar search) and other enduring learning materials about Native Hawaiian health and culture. The number of Native Hawaiian physicians has increased from 12 in 1975, to more than 325 worldwide in 2018. The majority of these physicians are graduates of the University of Hawaiʻi School of Medicine (ʻAhahui o nā Kauka, 2019; Ambrose et al., 2012). An estimated 72% of the total number of Native Hawaiian physicians worldwide live and practice in Hawaiʻi; however, they make up only 3.4% of all licensed and practicing physician in Hawaiʻi (ʻAhahui o nā Kauka,

[1] Based on Indian Health Service date collected from 2015-2019 (Indian Health Service Profile Fact Sheet, downloaded from: https://www.ihs.gov/newsroom/factsheet/ihsprofile/)

2019; Ambrose et al., 2012). There have also been substantive increases in nursing, social work, and other health care professions, and in the health and life sciences (Minton, Taʻafaki & Ng-Osorio, 2017; Mokuau et al., 2016). The use of cultural and traditional healing methods is rising (Donlin, 2010; Galang & Foye, 2014; Genegabus, 2017; Hewett, Alailima, Kamakea-Ohelo, & Mann, 2001; Peʻa, 1990).

During fiscal year 2017-2018, Native Hawaiians made up 44.5% of the 3,210 adults and 44.7% of the 1,977 adolescents receiving treatment for alcohol and substance use disorder from the Hawaiʻi State Department of Health Alcohol and Drug Abuse Division (2019). Native Hawaiian cultural practices and healing are being integrated into treatment interventions for alcohol and substance disorders (Like, Gray, & Yurow, 2013; National Association of State Alcohol and Drug Abuse Directors [NASADAD], 2009; Yurow & Daniels, 2019). Additionally, culturally aligned suicide prevention efforts have intensified, particularly for youth (Goebert & Sugimoto-Matsuda, 2017), an area in which there were insufficient data in 1985 for youth and young adults.

Despite these gains, Native Hawaiian health disparities remain severe. For example, life expectancy remains lower for Native Hawaiians than all other major groups in Hawaiʻi (Wu et al., 2017). Hawaiʻi's average life expectancy is 82.4 years; however, for Native Hawaiians, it is 76.6 years, which is approximately 6 years less, and approximately a decade less compared to Asian populations in Hawaiʻi. Moreover, Native Hawaiian morbidity and mortality rates for cardiovascular disease, stroke, diabetes mellitus, cancer, asthma, and substance abuse are unchanged from 1985 (see Chapter 2: Mental and Behavioral Health and Wellness, and Chapter 3: Medical Health). Native Hawaiian teenage pregnancy rates remain the highest among all Hawaiʻi adolescents (Aparicio, Birmingham, Rodrigues, & Houser, 2018; Hawaiʻi Health Data Warehouse, 2016) and is worsening with the growing numbers of homeless, of which 44.4% are Native Hawaiian (Yuan, Stern, Gauci, & Liu, 2018). Among Native Hawaiian youth and young adults, anxiety, depression, and suicide are major sources of morbidity and mortality (Andrade et al., 2006; Goebert & Sugimoto-Matsuda, 2017). This situation warrants a renewed call to action.

Part of the work of the *E Ola Mau a Mau* leaders and contributors has been to identify the factors that might explain these mixed findings of gains and remaining disparities and gaps within each of their chapters. As a preliminary starting point, Andrade (2017, 2018) proposed five common themes or causal factors that explain these findings:

1. **Resources**: Insufficient legislative funding to develop and sustain a well-functioning health care system, i.e., funding provided amounts to $45 per Native Hawaiian per year in the State of Hawaiʻi.

2. **Model**: An optimal model was not developed to establish and operate the Native Hawaiian Health Centers. In 1988, the original health care practitioners' organization E Ola Mau, Inc.,[2] conceived of what was called the Ahupuaʻa Model, which was a model of health based upon land, household, and family. This group naively expected that they would be asked to develop and implement this Ahupuaʻa Model. Instead, an Indian Health Service approach was first used and then withdrawn after resistance from Native Hawaiians. In place of a cohesive, unifying model, local communities were left to design their own models, often without expert health care administrative guidance and consultation. The result was an insular, localized diversity that lacked a framework within which consistent collaboration, shared principles and goals, and exchange of ideas and learning could seamlessly occur.

3. **Authority**: The envisioned coordinating body, Papa Ola Lōkahi, was legislatively assigned a whole slew of duties, but given neither the statutory authority nor sufficient funding to coordinate and provide a framework of unifying principles and standards of quality and common goals throughout the Hawaiian Islands. They led on an administrative model of cooperation and goodwill rather than coordination and oversight. Despite these obstacles, Papa Ola Lōkahi remains one of the great strengths of the Hawaiian Health Law.

[2] In 1987, the Native Hawaiian health professionals and Traditional Native Hawaiian healers and cultural practitioners who were coauthors and co-contributors of the 1985 *E Ola Mau Health Needs Study* formally organized into a 501(c)(3) non-profit organization and named their health care organization E Ola Mau, Inc. Its membership grew during the subsequent years, including Native Hawaiian health professionals, allied health professionals, and traditional Native Hawaiian healers and cultural practitioners from all major islands of Hawaiʻi.

4. **Participation**: Only approximately 10% of Native Hawaiians living in Hawai‘i sought services, despite health promotion and education programs (Papa Ola Lōkahi, 2018).

5. **Treatment Unit**: Individuals, rather than families and communities, were primarily treated, based on a biomedical paradigm rather than a bio-psycho-social-spiritual paradigm consistent with Native Hawaiian values, practices, and aspirations. The social determinants of health were largely neglected. The exception was the traditional cultural practitioners who worked largely in family-centered treatments.

Therefore, the leaders of this *E Ola Mau a Mau – Native Hawaiian Health Needs Study* of 2019 commit themselves to rekindling trust among Native Hawaiians, and other ethnocultural groups who support indigenous Hawaiians, that local and national leaders at every social, political, economic, spiritual, and cultural level will join us to work toward and achieve the goal and vision of optimal Native Hawaiian health in Hawai‘i.

Ola—Life, Health, Healing, and Well-Being

A major part of the work on the 2019 *E Ola Mau a Mau* report has been geared toward developing new ways of thinking about Native Hawaiian health. Ola is the Native Hawaiian cultural concept of life, health, healing, and well-being.

In the *E Ola Mau* report (1985), the central model for health was the cultural concept of Lōkahi, which was rooted in health for 18th- and early-19th-century Native Hawaiians who were thriving with a population of over 600,000 (Goo, 2015). Lōkahi means harmony or balance within oneself, with others, with the divine, and with the environment. One may become ill when lacking in any aspect of balance or harmony.

The 30-year outcomes of the Native Hawaiian Health Care Law indicated that Lōkahi was not the most effective cultural concept to use in the Native Hawaiian health care system that was developed (Papa Ola Lōkahi Historical/Cultural Task Force, 2017). This finding tells us that cultural concepts that worked in the past are not generic in their effectiveness. They are contextual and specific to the circumstances and challenges that one is attempting to address. For example, Lōkahi was indeed a powerful cultural concept for the men and women who made up the crews of Native Hawaiian voyaging canoes that recently completed their three-year sailing voyage around the world. On the voyaging canoe, diversity is framed within the unified focus of survival and success on the open ocean.

In contrast, the cultural concept of Ola has always been at the forefront of the Native Hawaiian Health Needs Study that triggered the public law. E Ola Mau may be translated as “To create and perpetuate Ola—health, life, healing, and well-being.” Within this context, Lōkahi is subsumed as part of Ola. Ola is the realization that you manage and protect your health and wellness by the choices you make, rather than leaving it to fate to allow an illness to decide if it is going to “get you”—the latter concept being perhaps a common perspective held by some Native Hawaiians.

The following story illustrates what Ola is *not*. In reflecting on the low participation of Native Hawaiians in health care services, the question can be posed: Why do Native Hawaiians not trust entering the health care system, despite growing numbers of Native Hawaiian physicians, nurses, etc.? During an all-day gathering with elders from every island for this update, the underlying reasons for this phenomenon were discovered. The elders shared the story of how leprosy devastated the fabric of Native Hawaiian families. The highly stigmatizing term “leprosy” is used intentionally, instead of Hansen’s disease, because it captures the fear, shame, and degradation that this term meant—and still means—for Native Hawaiians.

Leprosy was the last disease epidemic that devastated the Native Hawaiian population, beginning in the mid-19th century. The Native Hawaiian quarantine laws made having leprosy a crime. Nearly every Native Hawaiian family has a story of one or more of their relatives—a mother, father, sibling, uncle, aunt, cousin (men, women, and children) being forcibly removed from their families, put on ships and later airplanes, and sent to Kalaupapa, the Leper Colony on Moloka‘i. The quarantine laws ruptured the family structure and left the families who remained at home immersed in guilt, shame, humiliation, and indescribable sorrow for their loved ones. When babies were born in Kalaupapa, they were immediately taken from their mothers and sent to be raised by their relatives. This practice continued into the 1950s. And tragically, the police who had to enforce these quarantine laws were often Native Hawaiians. The phenomenon of historical trauma, described in more detail later in this chapter, refers to horrific losses such as the shattering of Native Hawaiian families. This story helps to comprehend viscerally the insidious and mostly unconscious effects of historical events which have resulted in diminishing and destroying Ola.

Native Hawaiians

The population of the United States now numbers 327 million (U.S. Census, 2018) and is increasingly diverse. By 2044, the U.S. population will become a

majority-minority population. It is estimated that by 2060, minority populations will account for 56% of the total population. In addition, 2020 will be a milestone year in which more than 50% of the population of children will come from minority groups (Colby & Ortman, 2015; U.S. Census, 2015).

The health of these minorities reflects the health of the United States in general. It is unfortunate that minority groups *continue* to suffer from the health disparities that were clearly noted in the 1985 comprehensive report to Congress, the Heckler report (Heckler, 1985). For example, the National Health Care Disparities report of 2013 found that, in general, disparities in quality of care and access to care related to race, ethnicity, or income showed no significant change (National Health Care Disparities, 2013).

Native Hawaiians are the indigenous people of the Hawaiian Islands, and they too suffer from significant health disparities. Although Native Hawaiian data on the national level can be hard to discern as much of the data have not been disaggregated, these disparities are identified from more detailed data gathered by the State of Hawai‘i. Hawai‘i is unique in that it has had no majority ethnic population since the 1890s. That is when Native Hawaiians became minorities in their homeland due to a rapid decline in population resulting from introduced infectious diseases, as well as an influx of immigrants from Asia who came to work on the sugarcane plantations.

Since that time, all ethnic groups in Hawai‘i have remained at less than 50% of the population, including the White population. The 2010 U.S. Census showed Hawaii’s population at 1,360,301 (U.S. Census Bureau, 2010), with the following breakdown:

- Asian: 38.6% total
  - Filipino: 14.5%
  - Japanese: 13.6%
  - Chinese: 4%
  - Other Asian: 3.9%
  - Korean: 1.8%
  - Vietnamese: 0.7%
- White: 24.7%
- Native Hawaiian: 21.3% (including part-Native Hawaiian)
- Mixed, Two or More Races: 9.5%
- Other Pacific Islander: 4.7% total
  - Other: 2.7%
  - Samoan: 1.3%
  - Micronesian: 0.7%
- Black or African American: 1.6%
- American Indian and Alaska Native: 0.3%
- All “others (mixed race and populations less than 0.5%)”: 15.8%

(U.S. Census Bureau, 2010 - Census Redistricting Data)

There were 527,077 Native Hawaiians in the United States in 2010, with just over half, 289,970, living in Hawai‘i (see Figure 2 for distribution across the United States). This amounts to only 0.1% of the United States population being Native Hawaiian, and given this small percentage, Native Hawaiians have often been aggregated with Asian Americans and other Pacific Islanders (Ka Huaka‘i, 2014). Such aggregation has resulted in the masking of many health disparities specifically affecting Native Hawaiians. For example, Asian Americans have the longest life expectancy in Hawai‘i, whereas Native Hawaiians have the lowest (Wu et al., 2017).

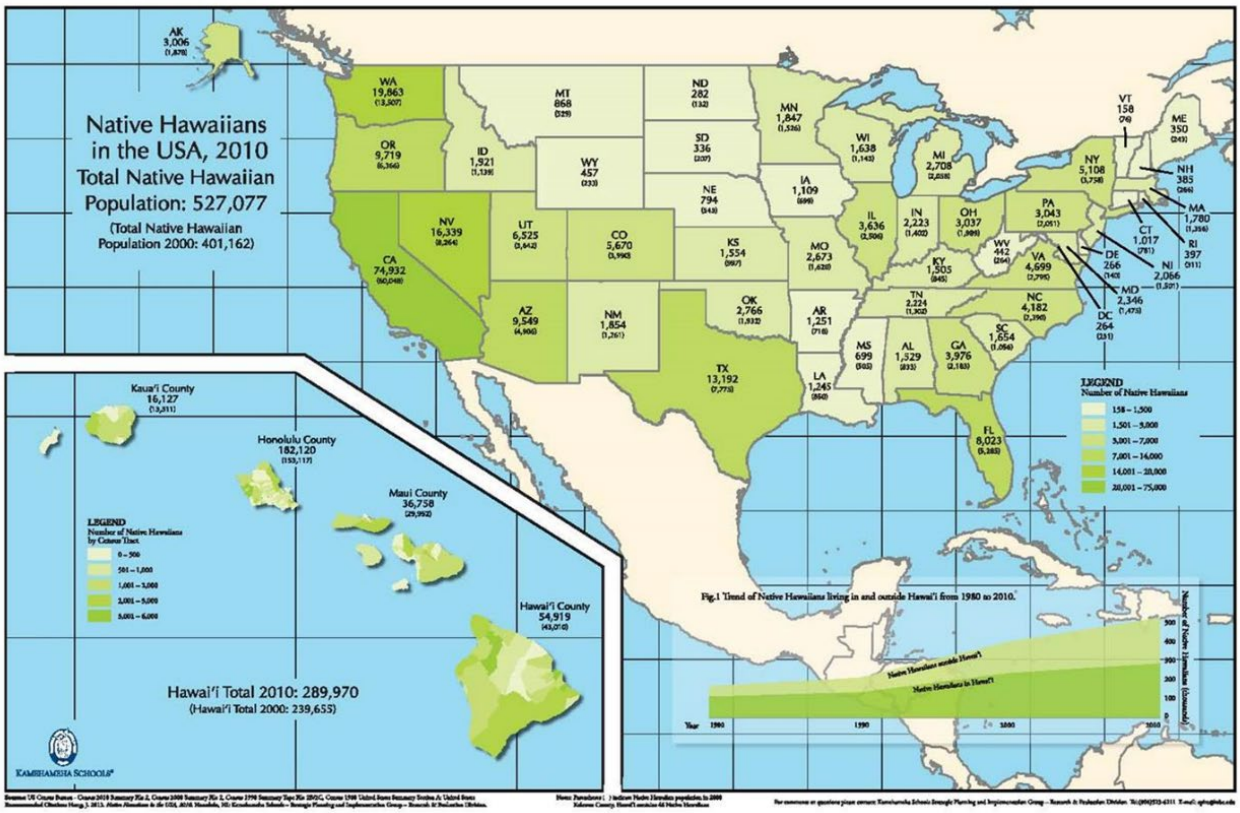


Figure 2. Distribution of Native Hawaiians across the United States (Ka Huaka‘i, 2014).

Ethnocultural Identity

Ethnocultural identity is at the core of well-being. Ethnocultural evolution refers to the iterative process by which groups define and redefine themselves over time by utilizing different dimensions of culture (e.g., language) to simultaneously distinguish and connect one group with another (McDermott & Andrade, 2011). It combines the concepts of ethnicity and culture. Ethnicity includes both the concept of kinship, or external relationships, and a concept of the inner identity that unites the past with the present and future. Culture is the principal marker to distinguish, and more importantly, to connect one group with another. Therefore, ethnocultural identity is the means by which a group maintains its distinctiveness—of kinship, as well as ancestral and home country ties—over time, while creating ways of sustaining connections with other groups that are essential to their society’s well-being.

The Native Hawaiian ethnocultural evolution can be described in two waves of historical events (McDermott & Andrade, 2011). The first wave, Renaissance (1810–1893), spanned nearly a century and began with the formation of a unified island nation by King Kamehameha I, whose reign was marked by the advancement of culture and the arts (Charlot, 1983). Ten months after Kamehameha’s death, the New England missionaries arrived. Filled with Christian zeal and Calvinist austerity, they tried to remake Native Hawaiians in their image—educated, literate, devout Christians practicing New England temperance. Remarkably, they created a Native Hawaiian alphabet, transforming the spoken ‘Ōlelo Hawai‘i[3] into a written language. Within five years of their arrival, 80% of the Hawaiian population was literate. The Congregational Church ruled alongside the Ali‘i[4] by creating “blue laws” that aimed to redefine Native Hawaiian ethnicity by stripping away selected aspects of Native Hawaiian culture from Native Hawaiians. Because of this, Native Hawaiian culture went underground. To the horror of the missionaries, Native Hawaiian culture and ethnic pride emerged audaciously at the coronation of King David

[3] Hawaiian language

[4] chief, chiefess, ruler, monarch, royalty, noble

Kalākaua, called the "Merrie Monarch." The reign of Kalākaua marked the cultural renaissance of Native Hawaiian culture while integrating European grandeur with the building of ʻIolani Palace. Today, his mark on history continues with the annual Merrie Monarch Hula Festival in Hilo, a world-renowned event dedicated to the perpetuation of Native Hawaiian hula, arts, and culture.

The second wave, Social Mobilization (from 1970 onward), has been a period marked by the creation of a professional middle class of doctors, lawyers, and academics. It began at the University of Hawaiʻi in 1970 with the establishment of a four-year medical school. The Medical School Dean, Terrence Rogers, who described himself as "a haole working-class Brit," announced at his first meeting with the department chairs, "We are going to create a new middle class—of Hawaiian doctors." He succeeded brilliantly. From fewer than 10 Native Hawaiian physicians, there are now nearly 300; from a class size of 2% Native Hawaiians in 1974, Native Hawaiians now make up 18% of medical students in Hawaiʻi. Among the first Native Hawaiian medical students to be a part of the medical school's social engineering was Dr. Noa Emmett Aluli—one of the core leaders of Kahoʻolawe. The University of Hawaiʻi Law School produced the core cadre of political activist lawyers (among them the first Native Hawaiian Governor) who became the leaders of Native Hawaiian movements to restore Native Hawaiian lands. The University of Hawaiʻi College of Education produced a cadre of Native Hawaiian language scholars who reintroduced the teaching of Native Hawaiian language into public schools and universities that led to the University of Hawaiʻi School of Hawaiian Knowledge—Hawaiʻinuiākea. The outcome was an unprecedented outpouring of Native Hawaiian publications and Hawaiʻi radio and cable television stations.

As the land was restored, the traditional practices of loʻi kalo,[5] hula,[6] hoe waʻa[7], and mālama ʻāina[8] began to return. In 1976, Mālama ʻĀina became the rallying call and core cultural practice of the Kahoʻolawe ʻOhana. It raised the public psyche to cohere into a multi-ethnic, bipartisan group with the singular purpose of taking back Kahoʻolawe. During the same year, the voyaging canoe Hōkūleʻa and its crew restored the traditional wayfinding of the ancient navigators—using the moʻolelo[9] of Kahoʻolawe and other sources as one of their sources to successfully sail to Tahiti and back. And finally, in 1985, the landmark *E Ola Mau – The Native Hawaiian Health Needs Study* was published, setting the strategic focus that became the Native Hawaiian Health Care System and further accelerating Native Hawaiian research.

These two waves of events show that the Native Hawaiian ethnocultural evolution has been, at times, destructive and traumatic, and at other times, restorative and creative—a spiraling progression of survival, rebuilding, resilience, and advancement. Key findings from a Native Hawaiian community survey indicated that 78% of Native Hawaiians believed it was important to live and practice Native Hawaiian culture on a daily basis; 73% reported an interest in developing their knowledge of Native Hawaiian language; and 83% reported being proud of their ethnic heritage, compared with 73% of non-Hawaiians (Kanaʻiaupuni, Malone, & Ishibashi, 2005). The learned, shared, and transmitted values, beliefs, norms, and ways of life of Native Hawaiians guide thinking, decisions, and actions in modeled, intergenerational ways (Leininger & McFarland, 2005).

Historical and Cultural Trauma

I think with Native Hawaiians, and some compare with the indigenous people of America, with the displacement of their culture and history, you see a lot of generational trauma, and because of this generational [historical] trauma, having a kind of negative outlook sometimes of what people are good at or good enough for. You know, you see the increases in our physical health problems, such as diabetes…So I think those kinds of things play a big role in a lot of our Hawaiian people and in the problems that they experience.

[To discourage these impacts,] I think a big one is kind of really going back to values of what it means to be Hawaiian. The Hawaiian values really range in the community. Like one is 'ohana, you know. The families. And really bringing back the importance of the family and helping one another, each other out. Helping them not only physically but helping them to kind of speak up for each other, doing more of the traditional hoʻoponopono .[10]

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Dr. Chun provides practical insight into the impact of historical trauma for his patients and families as well as ways to build resilience. Historical or cultural trauma is the cumulative emotional and

[5] taro farming
[6] Hawaiian practice of dance
[7] Canoe paddling
[8] traditional forestry to heal, restore, and sustain the land
[9] history or stories
[10] process for setting things right

psychological wounding over the lifespan and across generations, emanating from massive group trauma (Blaisdell, 1989; Blaisdell & Mokuau, 1991; Brave Heart, 1998, 1999a, 1999b, 2000; Brave Heart & DeBruyn, 1998; Brave Heart-Jordan & DeBruyn, 1995; DeCambra, Marshall, & Ono, 1998; Mokuau & Matsuoka, 1995; Trask, 1993, 1994). In a groundbreaking series of works, Brave Heart tied the plight of American Indians to the Holocaust experience—genocide, ethnic cleansing, and policies of forced acculturation. This analysis was preceded by local efforts to describe the impact of colonization on indigenous Hawaiians. Native Hawaiians have experienced a unique history of oppression and colonial exploitation which may contribute to poor health (Blaisdell & Mokuau, 1991; DeCambra et al., 1998; Kanahele, 1986; Mokuau & Matsuoka, 1995; Trask, 1993, 1994). Historical trauma is akin to kaumaha[11] syndrome—profound grief rooted in collective sadness and moral outrage (Kaholokula, 2007; McCubbin, Ishisaka, & McCubbin, 2007; Rezentes, 1996; Streltzer, Rezentes, & Arakaki, 1996). Historical trauma theory posits that while contemporary indigenous life has adapted, a significant proportion of Native people have poor well-being, in large part due to massive traumas (e.g., physical, emotional, social, and spiritual genocide) occurring in the past. Whitbeck, Adams, Hoyt, and Chen (2004) developed scales to measure historical trauma and its effects, finding that the current generation of American Indian adults not only had frequent thoughts about historical losses, but that these losses were associated with negative feelings of anxiety, depression, anger, and avoidance. Similarly, historical trauma has been demonstrated to be a predictor of substance use among Native Hawaiian college students (Pokhrel & Herzog, 2014). This study also found that historical trauma may have a protective effect against substance use, suggesting that thoughts and awareness related to historical trauma may not be harmful to health if issues associated with contemporary ethnic discrimination were addressed and individuals were equipped with skills and resources to manage stress or distress associated with perceived discrimination. Thus, there is a connection between historically traumatic events and contemporary stressors impacting physical and emotional well-being.

Within the context of historical trauma, the annual Navy bombing practice on the island of Kahoʻolawe and its representation of the modern-times destruction of an island, as well as the ethnocultural meaning the practice had—and still has—for Native Hawaiians (Andrade, Goebert, & Hishinuma, 2011), is reflected upon in this section. Kahoʻolawe, along with its surrounding reefs and seas, is used as a metaphor for Native Hawaiians and the history of the trauma they and their culture sustained—as well as how culture healed them. Historical trauma theory and its related manifestations of symptoms are explained, specific Native Hawaiian examples are offered, and ways to incorporate historical trauma into resilience, ethnocultural evolution, and healing in Hawaiʻi are described.

The sacred Hawaiian island of Kahoʻolawe is the kino lau[12] of Kanaloa—one of the four great gods or Akua of Native Hawaiian mythology (Melville, 1969; Valeri, 1985). The four Akua are: (1) Kāne, the god of fresh water, life, fire, and light; (2) Kū, the god of aggression, debate, and man-made creations, including war; (3) Lono, the god of healing, peace, the harvest, play, and sensuality; and (4) Kanaloa, Akua of the oceans and all living marine creatures; he is the god of mariners and navigators who sail through his vast domain. In most of the Pacific regions, Kanaloa is not seen as one of the major gods, but in Hawaiʻi, not only is he one of the four major Akua; his kino lau is an entire island dedicated to the ancient navigators. These ancient mariners believed that from Kahoʻolawe, the houses of the star constellations—along with powerful ocean currents leading into the ʻAlenuihāhā channel (the third most treacherous channel in the world) between Maui and Hawaiʻi island—would, at the right time of year, guide their great voyaging canoes back to the ancestral homeland of Tahiti. Voyagers to Hawaiʻi traveled across a distance of 5,000 miles of open ocean with family and others who served their personal, spiritual, military, and workforce needs. They also brought back domestic animals, plants, food, clothing, nets, rope, and other provisions needed for settlement. These ocean voyages required the support and guidance of the god of the sea; thus, Kanaloa became one of the paramount gods of Hawaiʻi. To destroy Kanaloa, as in the bombing and devastation of Kahoʻolawe, was to destroy the physical manifestation of a profound spiritual-cultural marker of Native Hawaiians' ancient history and oceanic prowess.

Historical trauma is the result of years of devastation. The symptoms associated with historical trauma encompass almost the entire range of psychopathology, including both internalizing (e.g., depression, anxiety) and externalizing (e.g., conduct disorder, substance use) symptoms (Whitbeck, Adams, Hoyt, & Chen, 2004). Undoubtedly, such effects on health and well-being are experienced by

[11] cultural loss

[12] Translated as "many bodies," referring to the many forms and physical embodiment of a god or divine being.

Native Hawaiians and the multicultural society for which they are the host culture, as described in Chapter 2: Mental and Behavioral Health and Wellness, and Chapter 3: Medical Health. Some Native Hawaiians refer to the ʻainoa, or breaking of the traditional spiritual system in 1819, as one of the first massive cultural traumas (Cook, Withy, & Tarallo-Jensen, 2003). Others point to the infectious diseases obliterating the Native Hawaiian population (see Appendix: Hawaiian Health Timeline and Events). Ongoing opposition contributes to the persistence of historical trauma, such as opposition to maintaining the integrity of iwi kupuna,[13] preserving wahi pana,[14] and recognizing the equality of the Native Hawaiian language with English as an official language of the State of Hawaiʻi (Liu & Alameda, 2011). This opposition may be exacerbated by the ethnic differential of social, political, and economic achievement in Hawaiʻi (see the section below on social determinants of health) and other perceived discrimination. The impact of historical trauma is widespread and may manifest in risky health behaviors and decreased well-being, contributing directly to pathways that increase the risk of chronic disease and mental illness (Crabbe, 1999; Kaholokula, Nacapoy, & Dang, 2009; Liu & Alameda, 2011). However, there is significant variation in how people experience and transmit intergenerational trauma (Denham, 2008).

Historical trauma is also the result of survival, which gives rise to resilience. Resilience typically refers to the positive capacity to cope with adversity as well as the ability to develop adaptive strategies that increase capacity for dealing with future negative events (Carlton et al., 2006; Masten, 2007). A number of factors and intervention components address the effects of historical trauma, and thereby enhance mental health and well-being. Native Hawaiians demanded an end to the military assault of Kahoʻolawe, and in 1976, activists occupied the island, making headlines across the country (Protect Kahoʻolawe ʻOhana, 2018). In 1990, the bombing stopped, and the Navy received funds to clean up the island. However, the cleanup was not completed, and other environmental problems remain. Native Hawaiians are restoring the island to its former health. Noa Emmett Aluli said, "We've taken on the biggest Navy in the world and held them responsible to the beliefs and practices of indigenous people…That is significant for the Native Hawaiian people."

Kahoʻolawe is one of the few places left in Hawaiʻi to learn about and immerse oneself in being Native Hawaiian (Protect Kahoʻolawe ʻOhana, 2018). Involvement in the Protect Kahoʻolawe efforts enables many Native Hawaiians to rediscover what it means to be Native Hawaiian and be trained in the rights and responsibilities of kahu o ka ʻāina.[15] Kahoʻolawe provides a place to experience meaningful connection to the culture, land, sea, kūpuna,[16] and akua.[17] Thus, Kahoʻolawe, as envisioned in the motto, "Kūkulu ke ea a Kanaloa,"[18] will be a cultural learning center where traditional cultural and spiritual customs, beliefs, and practices of the Native Hawaiian people can flourish. "E Kahoʻolawe, e hoʻomālamalama hou ana ka mauli ola Kohemālamalama" means "Kahoʻolawe, the Native Hawaiian lifestyle will again shine forth and flourish at Kohemālamalama."

Clearly, culture is reflected in help-seeking patterns, coping styles, social networks and support systems, the role of stigma, and treatment engagement (Satcher, 2001). To achieve cultural competence, the whole person as a cultural being must be observed and understood. To this end, resilience, family relationships, social and interpersonal stressors, and cohesion and functioning around family and community needs must be assessed. Furthermore, building cultural strengths reduces symptom dysfunction. This entails cultivating resilience in the face of multiple challenges; and developing coping strategies that enhance kinship ties, spirituality, and the creation of positive meaning. Programs that integrate cultural processes enhance participation, leading to improved self-concept, connectedness, health, and wellness (Carlton et al., 2011; Hill, 2006; Liddell & Burnette, 2017). This concept is imparted in the lyrics and music of "Mele O Kahoʻolawe" by Harry Kūnihi Mitchell (1977), who has played an integral role in the recovery of Kahoʻolawe. The last verse of this song gives hope for the future:

Hanohano nā pua o Hawaiʻi nei
No ke kaua kauholo me ka aupuni
Paʻa pu ka manaʻo o no ka pono o ka ʻaina
Imua nā pua
Lanakila Kahoʻolawe

Popular are the young people of Hawai'i nei
For the civil strife they cause against the Government
Together in one thought to bring prosperity to the land
Forward, young people and bring
Salvation to Kaho'olawe

Indigenization

[13] Native Hawaiian human remains
[14] sacred sites
[15] stewards of the land
[16] elders, ancestors
[17] gods
[18] "The life and spirit of Kanaloa builds and takes form."

Indigenization is understood as ways of translating social forces into pedagogical processes in a socio-historical-political context (Singh, 2002). After years of colonization and historical trauma, indigenization entails "a belief that situations can be transformed, a belief and trust in our own peoples' values and abilities, and a willingness to make change…into the more positive rebuilding energy needed in our communities" (Wilson, 2004, p. 76). Indigenization occurs when Native Hawaiian ways of knowing and teaching of cultural knowledge and social voice prevail (Trinidad, 2009). Indigenization also means defining an identity and mission relevant to the community to which the organizations serving Native Hawaiians must be accountable, such as genealogy, propriety of traditional practices, wisdom of elders, servant leadership, sense of place, environmental kinship and spirituality, collectivism, and restorative values over retribution (Matsuoka, 2007*).* "Ko koa uka, ko koa kai," those of the upland, those of the shore (Pukui, 1983), can be used as a metaphor for bringing together many ways of seeing, knowing, and feeling for a collectively established purpose (Morelli & Mataira, 2010).

Indigenization represents a paradigm shift in developing, implementing, and sustaining Native Hawaiian programs by linking interventions to a sense of community (Kanahele, 1986; Meyer, 2001; Trinidad, 2009). Yet, far too many clinical and community-based health practices aimed at serving indigenous youth, adults, and elders often impose epistemological (i.e., ways of knowing) approaches that do not recognize cultural knowledge, values, or history, or the voices of the Native Hawaiian community (Trinidad, 2012). Native Hawaiian communities need to tell their stories and share their traditions and cultural practices in order for both communities and practices, once seen as marginalized, to become sources of hope and inspiration (Grande, 2008; Smith, 1999; Trask, 1993; Trinidad, 2009).

Native Hawaiian epistemology creates a sense of place, with community history at its center, and deepens the meaning of cultural values and knowledge in community action (Trinidad, 2009). A key component in this process is participation in creating knowledge that is relevant to culture, the history of exclusion, and how culture and history affect people individually and collectively. Such knowledge can spread to affect positively the well-being of one's family, work, and community.

Lawe i ka maʻalea a kūʻonoʻono.

Take wisdom and make it deep.

ʻŌlelo Noʻeau #1957
(Pukui, 1983, p. 211)

Indigenization is not exclusive; it can find value in Western notions of knowledge and education for Native peoples that can contribute to a fuller understanding of the world (Meyer, 2008; Reyes, 2016). Within Western educational spaces, Native peoples can seek to recognize how colonialism has shaped their experiences, to comprehend their past through a Native lens, to emphasize the value of Native ways of knowing, and to develop new ways of knowing that are rooted in the beliefs and understandings of their ancestors that will empower Native peoples (Grande, 2008; Reyes, 2016; Smith, 1999). By utilizing education with indigenous means and purposes, Native peoples can begin to heal from historical trauma and revitalize their communities (Denzin & Lincoln, 2008; Grande, 2008; Smith, 1999). Native scholars also become adept with Western academic tools that might be centered on Native values and community needs (Brayboy, 2005; Reyes, 2016).

Participation in higher education can be especially critical in preparing Native students with knowledge, skills, and social capital that can be used to work toward strengthening the political, economic, social, cultural, and spiritual well-being of Native nations (Brayboy, Fann, Castagno, & Solyom, 2012). For example, Hawaiʻinuiākea School of Hawaiian Knowledge seeks "to pursue, perpetuate, research, and revitalize all areas and forms of Hawaiian knowledge, including its language, origins, history, arts, sciences, literature, religion, education, law, and society, its political, medicinal, and cultural practices, as well as all other forms of knowledge" (Hawaiʻinuiākea School of Hawaiian Knowledge, 2018). Such indigenous programs are tied to community, self-determination, and sovereignty and are accountable to the needs and priorities of Indigenous peoples (Denzin & Lincoln, 2008; Grande, 2008; Meyer, 2003, 2008; Reyes, 2016; Smith, 1999). Thus, knowledge and attainment of knowledge are attached to kuleana[19] (Meyer, 2001; Reyes, 2016). Native Hawaiian scholars have a responsibility to utilize knowledge in ways that contribute to community well-being within Native Hawaiian communities, as well as using indigenous pedagogy to obtain knowledge throughout the process (Reyes, 2014, 2016).

Social and Cultural Determinants of Health: A Systems Approach

[19] responsibility

Mōhala i ka wai, ka maka o ka pua.

Unfolded by the water are the faces of the flowers.

Flowers thrive where there is water, as thriving people are found where living conditions are good.

ʻŌlelo Noʻeau #2178
(Pukui, 1983, p. 237)

In understanding the underlying causes of chronic diseases, such as anxiety, depression, diabetes, and cardiovascular disease, the focus has traditionally been on genetic (i.e., hereditary traits), biological (high blood pressure, high blood cholesterol and obesity) and lifestyle (e.g., personal choices in diet and exercise) factors and access to quality health care. However, these factors are only the tip of the iceberg when it comes to accounting for the health inequities observed across ethnic and racial groups in the U.S. Collectively, biological factors, lifestyle behaviors, and access to health care account for only 30% to 50% of chronic disease prevalence. The other 50% to 70% is attributed to political, social, economic, and environmental factors, such as exposure to discrimination, lower educational qualifications and income, and issues of neighborhood safety and walkability (Catlin, Jovaag, Givens, & Van Dijk, 2016).

For example, income is strongly associated with longevity across all states in the U.S., including Hawaiʻi, even after accounting for access to health care (Chetty et al., 2016; Neumayer & Plumper, 2016). Income is also strongly associated with infant mortality and adverse birth outcomes in the U.S. (Komro, Livingston, Markowitz, & Wagenaar, 2016). Essentially, the more you make, the longer you live. Ethnic and racial discrimination is associated with indices of psychological distress, obesity, hypertension, cardiovascular disease, and adverse birth outcomes in many U.S. ethnic minority populations, including Native Hawaiians (Kaholokula, 2016). People of ethnic minority status, including Native Hawaiians, are more likely to live in obesogenic environments—that is, neighborhoods and communities that increase a person's risk for obesity because of poor access to healthy food and physical activity options, and safety issues that make regular physical activity challenging (Mau et al., 2008). Collectively, these political, social, economic, and environmental factors are referred to as the social determinants of health.

Social Determinants of Health

Social determinants of health are the societal, political, and economic forces that influence the social structure and hierarchy and the distribution of power, resources, and opportunities in society that differentially impact the health and well-being of people. Social determinants of health help to explain health inequities among groups in the U.S. The World Health Organization defines health inequalities as inequities among groups of people within society that are avoidable because of social and economic conditions that place certain groups at risk for disease and illness (World Health Organization, 2018). In the U.S., those experiencing the greatest health inequalities linked to social determinants of health are Indigenous peoples, ethnic minorities, people of lower socioeconomic status, and people living in rural communities (e.g., Smedley, Stith, & Nelson, 2003). This is a social justice issue because these inequities are avoidable.

Cultural Determinants of Health

Cultural determinants of health are the sociocultural conditions that influence group differences in health status. Cultural determinants are most relevant to Indigenous peoples who aspire to preserve their cultural traditions, to protect their sacred places and access to ancestral lands and resources, and to assert their indigenous identity and prerogatives. However, their values, practices, and aspirations are often at odds with those of the U.S. mainstream. A long history of physical, emotional, and cultural marginalization due to discriminatory acts and compulsory acculturation strategies (e.g., banning of Native languages) has adversely impacted the health and well-being of Indigenous peoples; this is often referred to as historical or cultural trauma (Kaholokula, 2017).

Social and Cultural Determinants of Native Hawaiian Health

Figure 3 illustrates the social and cultural determinants of Native Hawaiian Health, which include historical events, the current political system, and environmental, socioeconomic, sociocultural, and interpersonal factors (Kaholokula, 2013; Native Hawaiian Health Task Force Report & Kaholokula, 2016). For example, there are historical events that have influenced present-day social and cultural determinants of health for Native Hawaiians, such as population decimation, Christianity and its

condemnation of traditional values and practices, land privatization, illegal overthrow of the Hawaiian Kingdom, ban on the Native Hawaiian language, militarization of Hawai‘i, tourism, migrations, and foreign investments. These have led to the displacement and marginalization of Native Hawaiians in their own homeland, causing disadvantages in education, housing, and workforce. The current political system and its allocation of resources influence the safety (e.g., crime and environmental toxins) and infrastructure (e.g., usable sidewalks) of neighborhoods, which in turn, influence a person's access to healthy foods, safe and clean parks, and quality educational opportunities. In turn, the availability and affordability of options for healthy food and physical activity influence a person's risk for obesity and obesity-related conditions, such as diabetes. Finally, the accessibility and affordability of quality health care influence a person's health status. Native Hawaiians are most likely to live, work, learn, and age in environments where conditions impacting health are notably unfavorable compared to people of other ethnic groups in Hawai‘i.

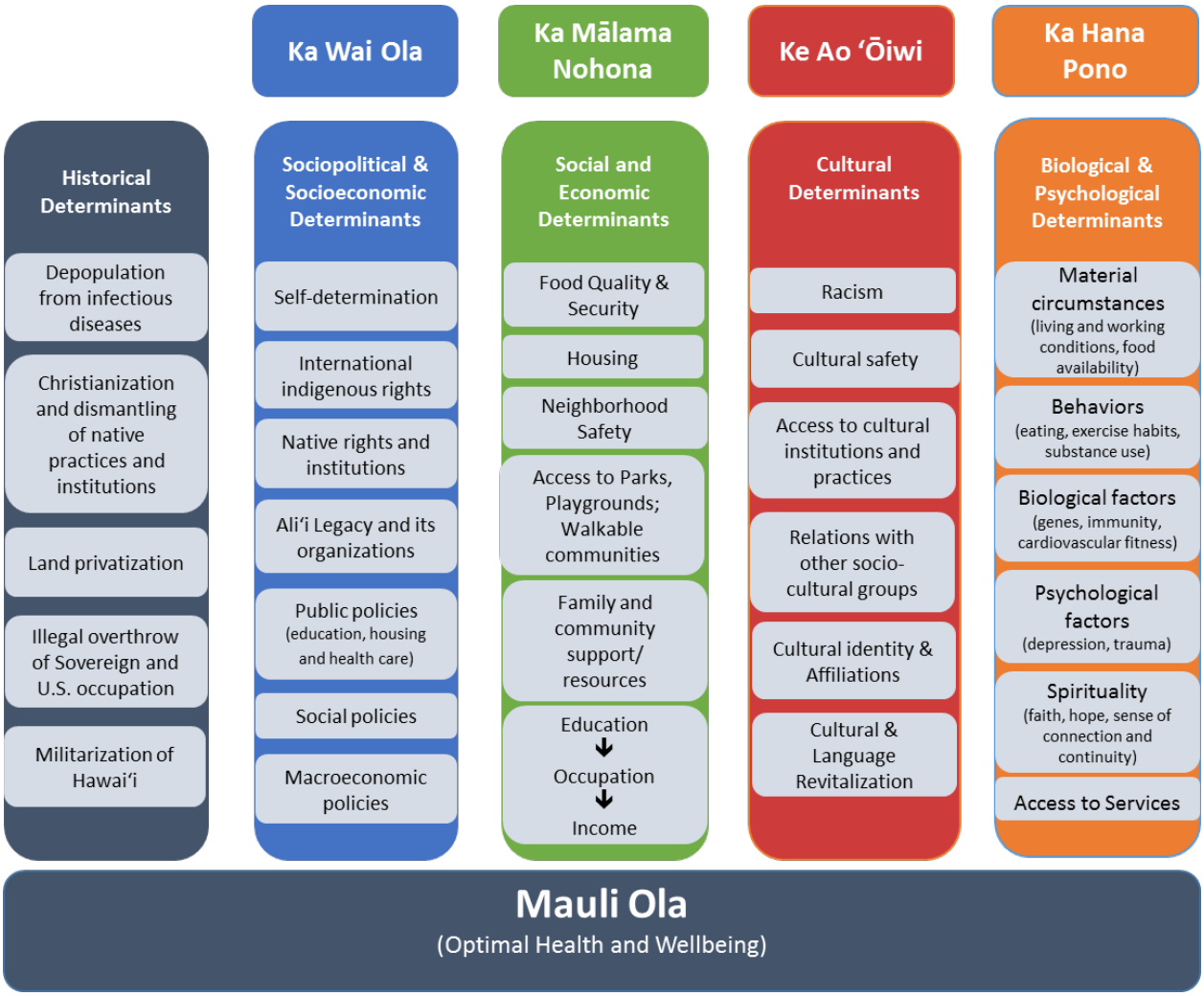


Figure 3. Social and cultural determinants of Native Hawaiian health.

Political Factors

What is now referred to as Hawai‘i was once a sovereign nation under the Kingdom of Hawai‘i following the unification of all the Hawai‘i islands in 1810 by King Kamehameha the Great (Dougherty, 1992). In 1893, a U.S.-supported coup led by American businessmen who were missionary descendants illegally overthrew the sovereign Queen Lili‘uokalani and proceeded to set up a provisional government. Eventually, Hawai‘i was annexed to the U.S. in 1898 and made the 50th State in 1959, despite U.S. President Grover Cleveland's declaration of wrongdoing by the U.S. in 1893. U.S. President William (Bill) Clinton, with the Apology Resolution (Public Law 103-150) in 1993, again recognized the U.S.'s role in the seizure and occupation of Hawai‘i. The international legal community recognizes Hawai‘i as being illegally occupied by the U.S. because Native Hawaiians never relinquished their claims to their inherent sovereignty over their national lands to the U.S. (Sai, 2015), "either through the Kingdom of Hawai‘i or through a plebiscite or referendum," as stated in U.S. Public Law 103-150. Many Native Hawaiian continue to seek some form of political self-determination (Goodyear-Ka‘opua, Hussey, & Wright, 2014; Silva, 2004).

Currently, Native Hawaiians do not share the same political status as American Indians and Alaska Natives with respect to the U.S. government, despite this tumultuous history. Native Hawaiians are not eligible for support from Indian Health Services and do not have any form of formal federal recognition or a means of exercising their sovereignty. There are three federal policies in place that serve to improve the status of Native Hawaiians with respect to housing (i.e., Hawaiian Homes Commission Act), education (i.e., Native Hawaiian Education Reauthorization Act), and health (i.e., Native Hawaiian Health Care Improvement Act). The State of Hawai‘i established the Office of Hawaiian Affairs (OHA) in 1978 under Article XII of the state's constitution. OHA was established to manage the assets set aside for the welfare of Native Hawaiians. These federal laws were established to address past injustices and their adverse impact on Native Hawaiians.

Environmental Factors

Neighborhoods with a higher concentration of Native Hawaiians are obesogenic neighborhoods. They are more likely to have more fast-food establishments and less physical-activity options (e.g., safe parks, usable sidewalks) than communities with a lower concentration of Native Hawaiians (Mau et al., 2008). For example, the Wai‘anae Coast of O‘ahu, where the highest concentration of Native Hawaiians reside in Hawai‘i, has among the highest number of automobile and pedestrian accidents and fatalities in Hawai‘i. Despite having a major high-traffic highway running through this region, the roads are absent of a median strip and usable sidewalks to prevent head-on collisions with oncoming traffic and to keep vehicles on the road. Traffic lights and pedestrian crossings are spread far apart along most of this highway; this set of circumstances increases the likelihood of jaywalking. The highway divides the residential areas from the beaches and parks. The more affluent communities of O‘ahu (i.e., Kāhala to Hawai‘i Kai) have median strips and sidewalks and more pedestrian crossings, and thus fewer automobile and pedestrian accidents and fatalities.

Economic and Educational Factors

Poverty, either alone or in combination with other factors, can contribute to inequitable health outcomes. For example, research suggested that living at or below 200% of the federal poverty level imposed a greater societal health burden than either smoking or obesity (Hawai‘i State Department of Health, 2011). Across Hawai‘i, communities with higher concentrations of Native Hawaiians face significant socioeconomic challenges. For example, more than 40% of the residents of Wai‘anae, Moloka‘i, and Hana live at or below 200% of the federal poverty level.

Education is a core component not only of socioeconomic status, but also of health status. Within Hawai‘i, the earnings benefit of a college education was found to be higher among Native Hawaiians than among other major ethnic groups, suggesting that economic forecasts for the Native Hawaiian population were closely tied to their educational future (Kana‘iaupuni et al., 2005). It was also found that disparities between Native Hawaiians and non-Hawaiians widened during the high school years. In addition, the Native Hawaiian labor force had a lower rate of college degrees, and there were fewer graduates in fields such as science, technology, and business that received higher wages (Naya, 2007). Fortunately, several educational advancements over the years have positively impacted the economic well-being of Native Hawaiians. The Native Hawaiian Education Act of 1988 triggered a surge of activity in the mid-1990s, including addressing the needs of gifted and talented students; developing educational and vocational curricula that incorporate Native Hawaiian knowledge; developing community-based learning centers to serve preschoolers and after-school students; and researching and evaluating the educational status and needs of Native Hawaiians

(Look, Trask-Batti, Agres, Mau, & Kaholokula, 2013).

Socio-Cultural and Interpersonal Factors

There is emerging evidence that factors related to interpersonal discrimination and acculturation (i.e., threats to cultural identity) are linked to the physical and mental health status of Native Hawaiians. The experience of discrimination by Native Hawaiians is associated with increased risk for psychological distress (Antonio et al., 2016; Kaholokula et al., 2017), obesity (McCubbin & Antonio, 2012), hypertension (Kaholokula, Iwane, & Nacapoy, 2010), and diurnal cortisol patterns associated with cardiovascular-disease risk (Kaholokula et al., 2012). In the biopsychosocial model of disease risk (Engel, 1997), the interpretation of an environmental event as being racist can lead to elevated psychological and physiological stress responses that intersect with socio-demographic, socioeconomic, and psychosocial stressors (Clark, Anderson, Clark, & Williams, 1999). Chronic activation of these stress responses can lead to abnormalities of the immune, neuroendocrine, and cardiovascular systems that increase risk for disease. The experience of racism affects physical health through psychological factors (Paradies et al., 2013). Perceived racism leads to psychological stress or distress for many people, which can manifest as depression, anxiety, emotional unrest, anger, resentment, and/or paranoia (Mohatt, Thompson, Thai, & Tebes, 2014).

A stronger cultural identity was found to be associated with suicidal attempts among Native Hawaiian adolescents (Yuen, Nahulu, Hishinuma, & Miyamoto, 2000) and diabetes risk among Native Hawaiian adults (Kaholokula, Nacapoy, Grandinetti, & Chang, 2008). Cultural identity appeared to be a marker of discrimination experience; studies have found a positive correlation between cultural identity and perceived ethnic discrimination in Native Hawaiians (Kaholokula et al., 2012; Kaholokula et al., 2010). It is likely that Native Hawaiians with a stronger cultural identity experience more cultural discord because of threats to this identity and challenges to their preferred modes of living (Kaholokula et al., 2009).

Conceptual Models of Ola

In Hawai‘i, for Native peoples, for indigenous Hawaiians, there’s another way, and perhaps we need to understand the Native and indigenous way and perspectives to contextualize how Hawaiians not only live and survive in today’s world in Hawai‘i but also may have a greater understanding of our historical cultural past that has contributed to a new state of being. And so, we should focus on our own traditional concepts of assessment, diagnosis, treatment development, and healing frameworks to help our own people adapt, adjust in Hawai‘i under a whole set of factors of Western intrusion. Why I say that is because the thing about medical treatment in Western medicine is the only concern is the individual. Hawaiian treatment concern is not only about you, the individual, but also does that have an impact on your ‘ohana?[20] *Does that have an impact on your community? Is that spreading to other families, other communities? And if it is, then it’s really about people. So, we got to learn how to treat people, healthy people, healthy communities, and healthy families.*

Kamana‘opono Crabbe, PhD
Chief Executive Officer
Office of Hawaiian Affairs
June 2017

Dr. Crabbe’s interview highlights the importance of using Hawaiian models of health and well-being to guide and care for the individual, family, community, and lāhui.[21] In addition to the overarching systems-level approach indicated above by Kaholokula, several models of Native Hawaiian well-being have been put forth by Native Hawaiian scholars, building upon and strengthening this understanding, and rooted in the seminal work of revered Native Hawaiian historian Mary Kawena Puku‘i (Handy & Pukui, 1998; Pukui, Haertig, & Lee, 1972; Wong-Wilson, 2016). While all models highlight the need for a wholistic approach to Native Hawaiian well-being, such an approach is far from universal. Current efforts focus on influencing sociocultural determinants to have a greater impact on Native Hawaiian well-being.

[20] family

[21] people

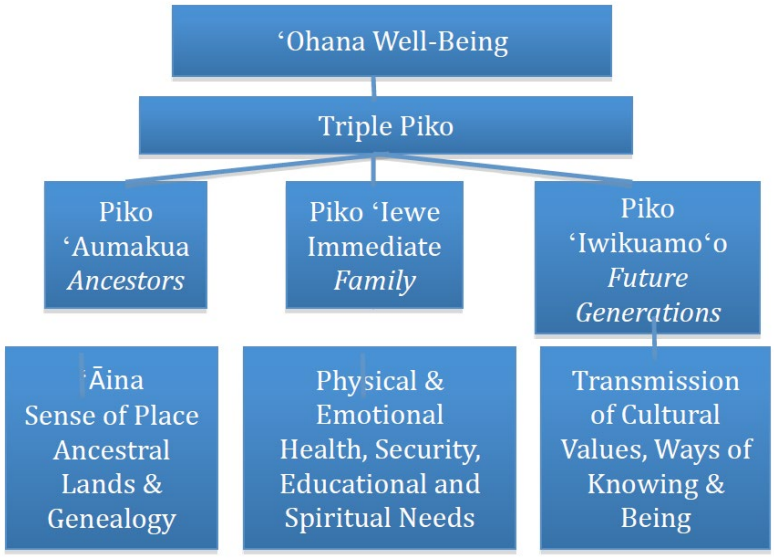


Figure 4. Mary Kawena Pukui's model of Native Hawaiian well-being (Adapted from Wong-Wilson, 2016, p. 112).

Rezentes (1996) proposed the Lōkahi Triangle to illustrate the indigenous concept of health (see Figure 5). His work focused on the importance of knowing one's ancestral ties and understanding connections to ʻāina[22] and Akua.[23] Health and well-being must be approached wholistically. Integrated mental, emotional, physical, and spiritual development enables Native Hawaiians to contribute to the cultural, linguistic, social, political, and economic development and sovereignty of their communities (Inglebert & Krebill-Prather, 2011). As health and well-being are addressed on multiple levels, people gain knowledge and skills that enhance their capacity to contribute to their communities.

In the ecological model of Native Hawaiian well-being, the emphasis shifts in scope from the individual to the ohana,[24] including community relations (McGregor, Morelli, Matsuoka, & Minerbi, 2003).

The dynamic model of Native Hawaiian well-being is illustrated by a flower (see Figure 6) in which the petals that represent emotional, social and cultural, physical, cognitive, and material and economic elements of well-being overlap in the center, indicating that these areas of well-being are interconnected and interdependent in forming the complete flower, and metaphorically the whole person (Kanaʻiaupuni, Malone, & Ishibashi, 2005).

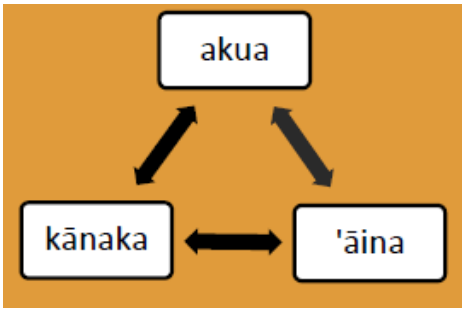


Figure 5. Lōkahi Triangle.

[22] land
[23] God, the supernatural
[24] family and extended family



Figure 6. Dynamic model of Hawaiian well-being (2005 *Native Hawaiian Education Assessment* – Kanaʻiaupuni, Malone, & Ishibashi, 2005).

Andrade (2006) developed a model of Indigenous Hawaiian ethnocultural identification to explain and predict how culture and ethnicity affect: 1) human development over the lifespan from infants to elders; 2) group affiliation and conformity to ethnic-group ideals; 3) levels of social function among individuals and their ethnic groups in a complex multicultural global community; and 4) ways in which individuals and groups define the existential meaningfulness of their lives, which allow them to be unique and different while they paradoxically remain an integral part of a unified whole (see Figure 7).

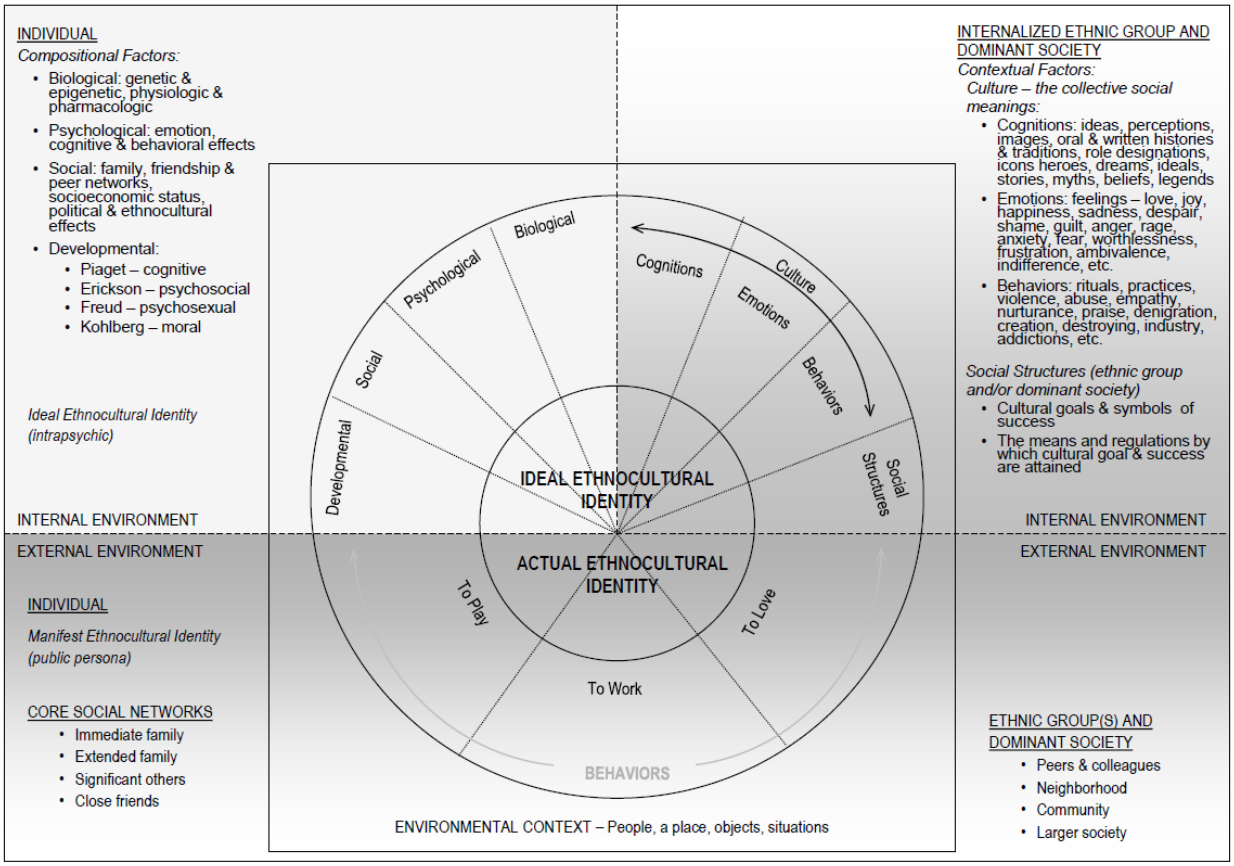


Figure 7. Ethnocultural Identification Dissonance Model

The relational world view of Native Hawaiian health and well-being is framed from an Indigenous perspective with interdependence, relationships, harmony, and balance at the center of the sphere, encircled by ancestors, culture, land, family, community, and nation (McCubbin, Kehl, Strom, & McCubbin, 2010). The core of this model is connectedness.

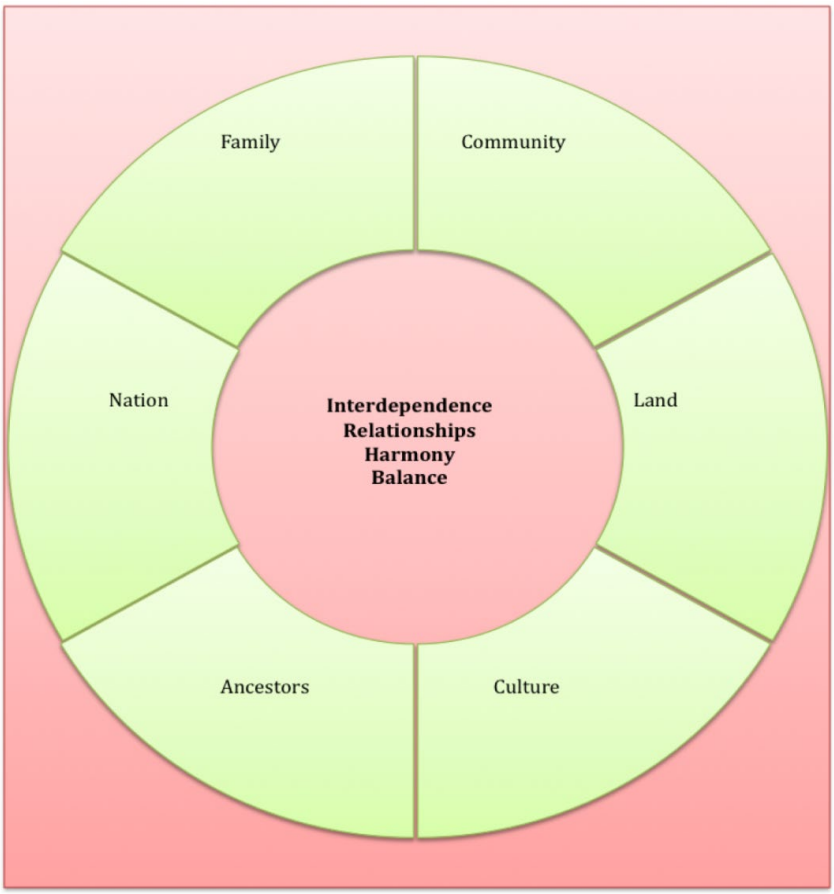


Figure 8. Relational worldview of Native Hawaiian health

The *Nā Pou Kihi* model of Native Hawaiian health and well-being includes four important domains (Kaholokula, 2014; Native Hawaiian Health Task Force & Kaholokula, 2016):

1. Ke Ao ʻŌiwi
   Native Hawaiian social and cultural space associated with health and well-being
2. Ka Mālama Nohona
   The quality of the environments where Native Hawaiians live, work, learn, play, and age that affect health and well-being
3. Ka Hana Pono
   Lifestyle choices and aspirations as Native Hawaiians strive for optimal health and well-being
4. Ka Wai Ola
   Attaining social justice through educational achievement and economic success for Native Hawaiians

Like the four corner posts of a solid house, each of the elements of *Nā Pou Kihi* are essential for optimal health. Figure 3 (above) also illustrates the alignment of *Nā Pou Kihi* with the social and cultural determinants of health.

ʻO ke kahua ma mua, ma hope ke kūkulu.

The site first, and then the building.

Learn all you can, then practice.

ʻŌlelo Noʻeau #2459
(Pukui, 1983, p. 268)

It is the hope of the contributors of *E Ola Mau a Mau* that this report will lay the foundation for future efforts.

Content-Area Update

Many brought their mana‘o,[25] ‘ike,[26] and hard work to breathe life into this report, thus making it a living document that is fluid in its recommendations and practice models. It is through these discussions and research that communities and organizations will continue to work on behalf of all of the lāhui.[27] The value of *E Ola Mau a Mau* with regard to improving the health and well-being of Native Hawaiians is critical. Health disparities cannot be adequately addressed by clinicians alone. It takes a community, including a community of health care providers, to address not only the disparities themselves, but the root causes of the disparities. Each chapter creates opportunities for dialogue within Native Hawaiian communities and establishes baseline data that can be reviewed on an ongoing basis to assist in determining needs, supports, and resources in these areas.

The Chapters

Building upon the Historical/Cultural Task Force Report of the 1985 *E Ola Mau Health Needs Study*, the 2019 *E Ola Mau a Mau* incorporates and reorganizes the original four task force reports (i.e., historical/cultural, mental health, medical, and nutrition/dental) into five chapters that reflect the growing knowledge and changes of the past three decades. These changes include new knowledge about how history, ethnicity, and culture shape indigenous health and well-being; advances in the clinical, biomedical, and public health sciences that yield new models and theoretical constructs to explain and predict how disparities occur and how they can be ameliorated; and how a new generation of health care and policy leaders are able to envision and oversee the next iteration of the 21st-century Native Hawaiian health care delivery system.

Two new chapters have been added to this publication: 1) Data Governance, encompassing the collection, management, uses, and dissemination of data, which are critical to assessing effectiveness and efficacy while ensuring quality, privacy, and engagement of health care users; and 2) Workforce Development, which examines how the underrepresentation of Native Hawaiians among health care providers including cultural healers and practitioners, as well as among health care educators and researchers, has been addressed during the past 30 years.

Chapter 1

Historical and Cultural Perspectives grounds the reader in the essential historical events and ethnocultural elements that underpin the unique, complex identity of Native Hawaiians, Hawaii’s indigenous, First Nations people. Chapter 1 sets the tone and evolving context of how and why Native Hawaiians remain in the 21st century C.E., a vibrant people with the will to rise above daunting health and social disparities, despite the historical trauma of deadly 18th- and 19th-century C.E. epidemics, the illegal overthrow of their sovereign nation, disenfranchisement, and government-sanctioned programs that attempted to obliterate their language, ways of teaching and learning, culture, health, well-being, and healing practices.

Chapter 2

Mental and Behavioral Health and Wellness draws together and critically examines the latest publications, reports, and perspectives concerning Native Hawaiian mental and behavioral health, interventions, programs, and policies based on a wholistic understanding of well-being. It identifies needs and provides guidance for the future.

Chapter 3

Medicine focuses on the five most common health disparities impacting Native Hawaiians: cardiovascular disease, diabetes, obesity, cancer, and asthma. The first three are examined within the context of cardiometabolic health and disease. The chapter presents new evidence and successful evidence-based interventions, with particular attention to interventions that involve culturally adapted programs within Native Hawaiian contexts.

Chapter 4

Nutrition reviews the current status of Native Hawaiians in Hawai‘i with respect to nutritional aspects of health and well-being. Specific public policies that have improved Native Hawaiian nutrition since the 1985 *E Ola Mau Study* are presented. In addition, existing services and initiatives are reviewed, along with promising approaches and programs that improve Native Hawaiian nutritional status and ameliorate, control, and/or avoid chronic illness.

Chapter 5

Oral Health updates our understanding of disparities, needs, gaps, and effective and promising programs in connection with Native Hawaiian oral health, based on a review of the literature and

[25] viewpoints
[26] knowledge
[27] people

interviews conducted with Native Hawaiian and non-Native Hawaiian oral health professionals who serve the Native Hawaiian community in Hawai‘i.

Chapter 6

Data Governance asserts a uniquely Native Hawaiian cultural approach to data practices from collection to dissemination of health data and results. The chapter describes the processes by which Native Hawaiians need to address data quality and scope, undertaking analyses of large data sets with the aim of achieving data sovereignty to regain control over quantitative, qualitative, and mixed-method methodologies. This will heighten the cultural relevance and utility of Native Hawaiian health data to continually improve the quality of Native Hawaiian health practices.

Chapter 7

Workforce Development identifies and critically examines models of success that have increased the numbers of Native Hawaiian health care workers, providers, educators, and researcher/evaluators. In addition, this chapter identifies health care workforce shortages and provides strategic recommendations for filling these shortages, based on a review of initiatives, programs, and models that have accelerated or hindered progress.

Each chapter is organized into four sections:

1. **Increased Understanding**
   Advances in our knowledge since the 1985 *E Ola Mau.*
2. **Effective and Promising Approaches**
   Description of selected effective or promising approaches to improve Native Hawaiian health.
3. **Gaps**
   Areas in need of improvement to optimize Native Hawaiian health.
4. **Recommendations for Impact**
   Actions needed to attain Ola, optimal Native Hawaiian health and well-being.

In the pages that follow, the authors/contributors of the *E Ola Mau a Mau Study* have attempted to provide the reader with sufficient breadth and selected areas of depth to demonstrate the scope, impact, and meaningfulness of the Native Hawaiian Health Care Act of 1988 (P.L. 100-579) and its reauthorizations in 1992 (P.L. 102-396) and in 2010 (P.L. 111-148).

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