E OLA MAU

THE NATIVE HAWAIIAN HEALTH NEEDS STUDY

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

The Native Hawaiian Health Research Consortium

ALU LIKE, INC.

Honolulu, Hawaii

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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 Oreeooa (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 witherto 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 fo the Legislature - Roster Legislatures 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 Kalākaua, February, 1887 (in Legends and Myths of Hawaii (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.148-149).

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 Natives 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.

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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 responsibile 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:

$$\text{INCIDENCE} = \frac{\text{ORGANIC FACTORS} + \text{STRESS} + \text{EXPLOITATION}}{\text{SOCIAL COPING SKILLS} + \text{SELF ESTEEM} + \text{SUPPORT SYSTEMS}}$$

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.[1]

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 Hawaii 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 Māhele" 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:

- o Hawaiian Homes Commission Act (July 9, 1921)
- o Hawaii National Park Extension Act (June 30, 1938)
- o Hawaii Admissions Act (March 18, 1959)
- o Community Services Act of 1974 (January 4, 1975)
- o Comprehensive Employment and Training Act (August 5, 1977)
- o Native American Religious Freedoms Act (August 11, 1978)
- o Youth Employment Act (October 27, 1978)

- o National Institute on Drug Abuse Legislation (January 2, 1980)
- o Native Hawaiian Study Commission (December 22, 1980)
- o Job Training Partnership Act (October 12, 1982)
- o Library Services and Construction Act (October 17, 1984)
- o 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 forbiding 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 for 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 for 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 overrepresentation 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 any one 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 lōkāhi (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) Pharmaceutics as part of rituals with symbolism including the empirical use of the narcotic 'awa, carthartic kukui and koali, poultice pōpolo, 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'ōla (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, reverance 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 health 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 enpowerment, 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 (<u>'āina</u>) 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, brochitis/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 esophagal 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 underutilize 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, expecially 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.

1. 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. There is a need to relate available data on diet and the incidence of heart disease, cancer, diabetes, arthritis, and gout among Native Hawaiians.

b. 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 (Waimānalo, Nānākuli, 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 disaproportionately 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, peridontal 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.

1. 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

RECOMMMENDATIONS 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. 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	Center 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

Task Force Recommendations

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
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.	State DOH, State DOE	HSIA, OHA, DHHS, HSI	State DOH
1.2 That there be a 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. 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.	State DOH, Legislature	HSIA, OHA, DHHS, HSI	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.	State DOH, Legislature	HSIA, OHA, DHHS, HSI	State DOH

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
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 programs 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 on professionals. Modern communication systems such as television should be used in developing these programs.	State DOH, Community Health Care Organizations, Legislature, State DOE	HSIA, OHA, DHHS, HSI, KS/BE	State DOH, Native Hawaiian Organizations
1.5 That there be encouragement for learned Native Hawaiians to teach and instruct other Native Hawaiians in health-related areas at all levels including hiapo (eldest sibling), makua (parents, uncles, aunts), and kupuna (grandparents, elders).	State DOH, Community Health Care Organizations, Legislature, State DOE	HSIA, OHA, DHHS, HSI, KS/BE, Hawaiian Civic Clubs	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 liasion with effective and respected native healers.	State DOH, Community Health Care Organizations	HSIA, OHA, HSI, KS/BE, DHHS	State DOH, Community Health 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	Health Organizations and Agencies	HSIA, OHA, DHHS, WCCHS	Native Hawaiian Groups, HSIA, OHA

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
services and programs rendered to it and providing the Native Hawaiian community such health services as was the intent of the founders of some of these health care institutions.			
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.	OHA, HSIA, HSI	State Agencies, Federal Agencies, Private Groups and Organizations	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.	State DOH, Community Health Care Organizations	Native Hawaiian Groups and Organizations	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.	State DOH, Community Health Organizations	NIMH, State DOH, Legislature	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.	Community at Large	OHA, State DOH, DMH	Native Hawaiian Agencies, HSI

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
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.	State DOE, UH, Private Schools	NIMH, KS/BE	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.	State DOH	DMH	DMH, Native Hawaiian Agencies
2.5 That third party payments for treatment services based on traditional Hawaiian orientation and practices be legitimized.	Legislature, State DSSH		DOH, Native Hawaiian Agencies, State Legislature
2.6 That political, economic, and social competence among Native Hawaiian people be developed and promoted.	Community at Large	KS/BE, OHA, Native Hawaiian Fundraisers	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.	UH, State DOE, Private Schools		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.	State Judiciary, DHHL, DLNR	Judiciary	Native Hawaiian Agencies, OHA, DHHL, NHLC
2.9 That social epidemiology studies focusing on family, work, and community expectations, performance, and adjustment of Native Hawaiians be conducted.	UH, State DOH	NIMH	Native Hawaiian Agencies, HSI
2.10 That research be done on community leadership development and natural support systems in the Native Hawaiian community.	UH, State DSSH	OHA	Native Hawaiian Agencies, HSI
2.11 That research be done on Native Hawaiian healers .	UH, State DSSH, State DOH	NIMH	Native Hawaiian Agencies, HSI

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
2.12 That a survey be conducted on service delivery and options and preferences for mental health services in the Native Hawaiian community.	State DOH	NIH, NIMH	Native Hawaiian Agencies
2.13 That Hawaiian language materials be translated to better understand Native Hawaiian health, history, culture, and values.	State DOE, UH, Legislature, Private Sectors	OHA	OHA, KS/BE, HSI
2.14 That there be developed ethnic identity scales which measure conformity to a range of lifestyles.	UH, State DOH	NIMH	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 predominently Native Hawaiian communities and to study the mental health related risk factors and hazards in the social and physical environments.	UH, State DOH, Health Care Organizations	State DOH, EPA, NIMH, NIH, DHHS, DOT, UH	State DOH, Native Hawaiian Agencies
2.16 That federal programs focusing on mental health be made accessible to Native Hawaiians and responsive to Native Hawaiian needs.	DHHS, Congress	OHDS, PHS, ADAMHA, CDC, HRA, HSA, NIH, HCFA	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.	Legislature, State DOH	State DOH	State DOH
3.2 That existing health care organizations include qualified Native Hawaiians on their boards.	Community Health Care Organizations		Community Health Care Organizations
3.3 That an umbrella body for monitoring and planning for Native Hawaiian health needs be established.	Native Hawaiian Community	HSIA, OHA, DHHS	Native Hawaiian Agencies

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
3.4 That Native Hawaiian parity in the health professions be targeted through scholarship programs and academic monitoring and support.	UH, KS/BE, Private Foundations	KS/BE, UH-SOM, OHA	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.	Health Care Organizations, State DOH	National Center for Disease Control, Native Hawaiian Organizations	Native Hawaiian Organizations
3.6 That health education, screening and health promotion programs be provided through community groups having high Native Hawaiian membership.	Health Care Organizations, State DOH	HSIA, Native Hawaiian Organizations, KS/BE, Health Care Organizations	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.	Health Care Organizations, State DOH	Health Care Organizations, State DOH	Health Care Organizations
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.	OHA, Judiciary, Queens Hospital, Lunalilo Home, Kapiolani Hospital	OHA, HSIA, Lunalilo Home, Queens Hospital, Kapiolani Hospital	OHA
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.	Hawaiian Organizations	Native Hawaiian Organizations	Native Hawaiian Organizations
3.10 That a cultural training program be developed for physicians working in Hawaii regarding traditional Hawaiian beliefs, attitudes and practices of health care.	Health Care Organizations, State DOH	KS/BE, HSIA, HSI	Health Care Organizations

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
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.	Health Care Organizations, State DOH	KS/BE, HSIA, HSI	Health Care Organizations
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.	Health Care Organizations	ALU LIKE, OHA KS/BE, HSI	Health Care Organizations
3.13 That traditional Hawaiian remedies be incorporated into the care of Native Hawaiians whenever medically feasible.	Health Care Organizations	ALU LIKE, OHA, KS/BE, HSI	Health Care Organizations
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.	State DOH, UH Health Care Organizations	KS/BE, ALU LIKE, HSI, State DOH, State DOE, UH	State DOH, UH, Health Care Organizations
3.15 That family planning services be maintained to promote family planning consistent with the health needs of parents and children.	Health Care Organizations, Planned Parenthood	KS/BE, ALU LIKE, Planned Parenthood	Health Care Organizations
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.	Health Care Organizations, State DOE	KS/BE, ALU LIKE, Health Care Organizations	Health Care Organizations

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
3.17 That health promotion programs 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.	Health Care Organizations	Health Care Organizations, Native Hawaiian Organizations	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.	Health Care Organizations	KS/BE, ALU LIKE, Health Care Organizations	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.	Health Care Organizations	KS/BE, HSIA, HSI, Native Hawaiian Organizations	Health Care Organizations
3.20 That more resources be provided to public schools to implement a comprehensive health education curriculum.	State DOE	KS/BE, HSI, State DOH, NIMH, U.S. DOE, Legislature	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.	Legislature, State DOE	HSIA, Private Sector	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.	Legislature	Health Care Organizations, Physicians	Health Care Organizations
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.	State DOE, Private Schools	State DOH, NIMH, DHHS	Native Hawaiian Organizations

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
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.	Legislature, State DOH	ALU LIKE, KS/BE, HSI, OHA	Native Hawaiian Organizations
3.25 That support be given to developing preventive and screening programs for cancers in Native Hawaiians.	Legislature, State DOH, Cancer Center	Cancer Center, ALU LIKE, KS/BE, OHA, Health Care Organizations	Native Hawaiian Organizations
3.26 That statewide screening programs for diabetes and hypertension be modified to target the Native Hawaiian population.	Legislature, State DOH	Health Care Organizations, ALU LIKE, KS/BE, OHA	Native Hawaiian Organizations
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.	State DOH	Health Care Organizations, Native Hawaiian Organizations	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.	Health Care Organizations, State DOH	Health Care Organizations, Native Hawaiian Organizations	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.	Health Care Organizations, Researchers, State DOH	Native Hawaiian Organizations	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.	Health Care Organizations, State DOH	Native Hawaiian Organizations, UH	Health Care Organizations, State DOH

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
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.	Health Care Organizations, Researchers, State DOH	Native Hawaiian Organizations	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.	Health Care Organizations, Researchers, State DOH	Native Hawaiian Organizations	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.	DHHS, Congress	OHDS, PHS, ADAMHA, CDC, HRA, HSA, NIH, HCFA	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.	State DOH, Community Health Organizations	State DOH, State DHHS	State DOH
4.2 That there be developed additional nutritional programs for Native Hawaiians focusing on child nutrition.	State DOH, Community Health Organizations	State DOH, State DHHS	State DOH
4.3 That there be developed additional nutritional educational programs for Native Hawaiians focusing on families and children.	State DOH	State DOH, State DHHS, KS/BE	State DOH, State DOE
4.4 That there be developed culturally-sensitive educational programs for Native Hawaiian children in elementary and secondary school.	State DOE, Private Schools	KS/BE, State DOH	State DOE, Private Schools

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
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.	State DOH, UH	State DOH, State DHHS	State DOH
4.6 That there be nutritional surveillance and monitoring of diets and health promotion of Native Hawaiians and other ethnic groups in Hawai'i.	State DOH	State DOH, State DHHS	State DOH
4.7 That there be a provision and promotion of traditional Native Hawaiian food resources.	Community at Large, State DOH	State Legislators, State Department of Land and Natural Resources	State DOH, State DOE
4.8 That there be positive efforts made to fluoridate Hawaii's water system.	Legislature, State DOH	State DOH, Legislature	State DOH
4.9 That there be provision for Native Hawaiians without dental insurance to receive needed dental care and treatment.	Legislature, State DSSH	State DOH	State DOH
4.10 That there be additional dental educational programs targeted at Native Hawaiians and their families.	State DOH	State DOH, State DOE, KS/BE	State DOH, State DOE
4.11 That there be additional school-based dental education and hygiene programs.	State DOE, Private Schools	State DOH, State DOE, KS/BE	State DOH, State DOE
4.12 That there be a culturally sensitive training program developed for teachers and dental health professionals.	State DOE, Private Schools, UH	KS/BE, HSI, UH	State DOH, State DOE
4.13 That there be a continuous effort to protect youngsters against dental injuries in competitive sports.	Community at Large	State DOH, Private Dentists	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.	State DOH	State DOH	State DOH

RECOMMENDATION	TARGET AGENCY	POTENTIAL RESOURCES	LEAD AGENCY(IES)
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.	State DOH	State DOH, EPA NIMH, NIH, State DHHS, DOT, UH	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.	DHHS, Congress	OHDS, PHS, ADAMHA, CDC, HRA, HSA, NIH, HCFA	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 predominently 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 summarized 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 -

- o Erosion of native cultural identity and alienation from the dominant non-native culture;
- o Increased crowding, traffic, and noises;
- o Environmental pollution through deteriorating air quality, water quality, and possible electromagnetic radiation;
- o Poor quality housing and the lack of affordable housing;
- o Inability of many schools to meet the individual educational needs of youngsters; and
- o 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 a 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 predominently 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

STRATEGY FOR IMPROVED NATIVE 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 commmitment 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 Hawaiians 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 martial 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 acceptibility. 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 acceptibility. 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 martial 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 HĀLAU A OLA
(Gain health by learning health)

Part IV

FOOTNOTES AND REFERENCES

IV. FOOTNOTES AND REFERENCES

Footnotes

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Part V

TABLES AND FIGURES

Table 1

HEALTH FACTORS AND RELATIONSHIPS

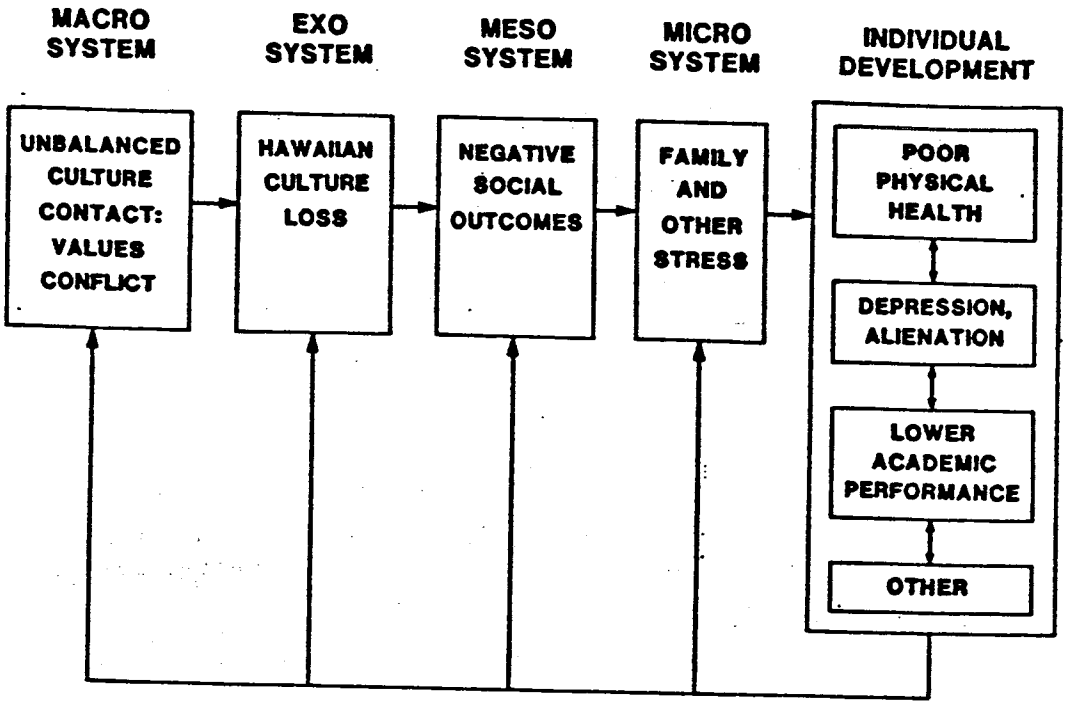
Responsible Factors	Mechanisms	Effects
1. LIFESTYLE		
o Individual behavior, habits	Diet	Heart, blood pressure, cancer, diabetes, carries
o Family and other role models, culture, education	Personal hygiene, self abuse (tobacco/alcohol)	Cancer, lung disease, cirrhosis, malformations, infections
o Faddism	Physical fitness	Heart
o Work ethic	Rest, recreation	Fatigue
o Culture	Stress-coping	Dispair
2. BIOLOGICAL FACTORS		
o Research	Heredity	Diabetes
o Mating (eugenic)	Cellular mechanisms	Cancer, atherosclerosis
3. ENVIRONMENT		
o Population control	Crowding	Stress, crime
o Government, industry	Pollution, insanitation	Infection
o Injustice	Loss of lands	Loss of culture, dispair
o Culture	Family disruption	Loss of culture, dispair
o Education opportunity	Aborted schooling	Misinformation
o Poverty, boredom	Crime	Homocide, toxicity
o Job training opportunity	Unemployment	Dispair, crime
o Economic policy	Poverty	Dispair, crime, uneducation
o Media, government	Propaganda	Ill-health
o Culture	Racism, discrimination	Dispair, ill-health
o Government, industry	Harmful chemicals	Toxicity
o Government, industry	Automobiles	Trauma, death
o Carelessness	Accidents	Toxicity, death
o Government, industry	Noise	Dispair, deafness
4. INADEQUATE HEALTH CARE		
o Education	Lack of health professionals	Ill-health
o Government	Lack of facilities	Ill-health
o Government	Lack of special supplies	Ill-health
o Education	Lack of proper information	Ill-health

FROM: Material provided by Dr. Richard Kekuni Blaisdell

Figure 1

(SEE PAGES 73-84 FOR A FULL DISCUSSION OF THIS CONCEPT)

THE CULTURE LOSS/STRESS HYPOTHESIS



This ecological model embraces four levels of interaction that may enhance or inhibit the learning of Hawaiian children. Each of these will be briefly described:

- **Microsystem** — This level is the most immediate to developing children and encompasses the actual setting of the youngster — the places they live, the people with whom they interact; parent-child relationships, teacher-child relationships, etc.
- **Mesosystem** — These are relationships between various microsystems in which the Hawaiian child experiences reality; for example, home:school, peer groups: school, etc. The richness of the mesosystems for the child depends on the number and quality of the connections. Minimal and/or conflicting linkages will place the child at risk, particularly if there is little agreement and overlap between home and school in terms of values, experiences, language, objects, and behavioral style. In such a disparate condition, the odds would favor poor academic achievement by youngsters.
- **Exosystem** — These systems bear upon a child's development and yet the child is not necessarily a participant at this level. They include such forces as school boards (and rules/regulations) and parents' work settings. Exosystems may contribute to at-risk conditions of Hawaiian children when the child's parents suffer in a way that negatively affects the child's learning, or when decisions made in such exosystems adversely affect the youngster. For example, a school board could prescribe a set of behavioral expectations in conflict with culture related values of the child's home. Exosystem risk occurs when the child lacks effective advocates in decision-making bodies. Thus, such risk may be largely a political matter — a matter of "clout."
- **Macrosystem** — These are the broad ideological and institutional patterns of a particular culture, the "blueprints" for human development. Macrosystems are the shared assumptions and shared expectations of a people. "Macrosystem refers to the general organization of the world as it is and as it might be. The existence of historical change demonstrates that the 'might be' is quite real, and occurs through evolution (many individual decisions guided by a common perception of reality) and through revolution introduced by a small cadre of decision-makers." (Garbarino, 1982, p. 24) Macrosystem risk occurs when an ideology or cultural alignment inhibits the educational development of the child by erecting learning barriers in the exosystems, mesosystems, and microsystems of that person. For example, patterns of racist values, economic sanctions, or political suppression or repression may be demeaning to parents and stress-producing in both parents and children to the extent of inhibiting the learning process.

These levels of a complex, interrelated system may be seen as nested hierarchically,

this systems theoretic concept avoids some of the pitfalls of the traditional linear explanatory models. Cause and effect are not considered a one-way street: events at the mesosystem level, for example, contribute to the developing macrosystem just as events at the higher system levels will inevitably have effects on the developing child. The implication is that changes at the upper levels have far-reaching consequences.

FROM: The Kamehameha Schools/ Bernice P. Bishop Estate, Final Report, Native Hawaiian Educational Assessment (p. 4).

Figure 2

NATIVE HAWAIIANS—A DYING RACE.

As shown by the following charts, the number of full-blooded Hawaiians in the Territory has decreased since the estimate of 1826 from 142,650 to 22,500, while the death rate has correspondingly increased until it is now greatly in excess of that of any other race inhabitating the islands:

Population—native Hawaiians.

Years.	Part Hawaiians.	Full-blooded Hawaiians.
1826, estimated by missionaries		142,650
Hawaii official census:		
1832		130,313
1836		108,579
1850		82,203
1853		71,019
1860		67,084
1866		58,765
1872	2,487	49,044
1878	3,420	44,088
1884	4,218	40,014
1890	6,186	34,436
1896	8,485	31,019
United States official census:		
1900	8,835	29,799
1910	12,506	26,041
1919, estimated June 30	16,660	22,600

Race death rate for year ending June 30, 1919.

	Death rate.
Hawaiian:	
Full-blooded	39.42
Part:	
Asiatic	14.58
Caucasian	16.17
Filipino	18.55
Korean	14.31
Chinese	14.12
Porto Rican	13.70
Japanese	13.35
Portuguese	12.48
Spanish	9.58
Caucasian, other than specified	6.26
All others	35.41

Furthermore, due to the rapid decrease in the number of the full-blooded Hawaiians, the race is fast becoming a minority element among the races of the Islands, with the probable result that in the future political control will pass into other hands. According to the latest estimates not only the Japanese and Portuguese, but also the Chinese, now outnumber the full-blooded Hawaiians.

From: US Congress, Bills, Reports, Hearings, and Acts: Hawaii (pages 120-123).

Population, all races.

Races.	Census of 1910.	Estimated June 30, 1919.
Japanese	79,675	110,000
Caucasian, other than specified	14,567	31,000
Hawaiian:		
Full-blooded	26,041	22,600
Part	12,506	16,660
Total Hawaiian	38,547	39,260
Portuguese	22,301	25,000
Chinese	21,674	22,800
Filipino		22,000
Porto Rican	4,890	5,400
Spanish	1,990	2,400
All others	7,964	8,808
Total	191,908	[1] 263,666

[1] The results of the 1920 United States Census, just announced, show the total population of the Territory to be 249,992. The results by races are not yet available.

And among the registered voters the full-blooded Hawaiian and the part Hawaiian combined are not holding their own with the other nationalities:

Registered voters, by races, at each general election.

	Population, 1910.		Registered voters.											
	Total.	Male citizens of voting age.	1900	1902	1904	1906	1908	1910	1912	1914	1916	1918	Gain.	Loss.
Hawaiian, full blooded and part	38,547	9,802	.....	8,680	9,260	9,635	8,967	9,619	9,435	10,308	10,763	10,901	138	.....
Portuguese	22,301	2,025	.....	594	728	939	1,230	1,530	1,769	2,317	2,610	2,844	234	.....
Chinese	21,674	670	.....	143	175	220	272	396	436	654	777	954	177	.....
Japanese	79,675	53	.....	3	2	.....	8	13	48	112	179	287	108	.....
American	29,711	5,783	.....	1,932	1,872	1,674	1,715	1,763	2,365	3,020	3,284	3,810	526	.....
British				546	542	563	567	554	544	629	648	636	.....	12
German				309	301	201	322	333	299	659	720	692	.....	28
Others				405	373	240	195	234	239	.....	.....	.....	.....	.....
Total	191,908	18,333	11,216	12,612	13,253	13,578	13,274	14,442	15,185	17,699	18,981	20,124	1,183	40
Increase	.....	.....	.....	1,396	641	325	304	1,168	743	2,514	1,282	1,143	.....	.....

Witnesses testified before the committee that the reasons for the decline of the Hawaiian race are many. Certain causes and remedies are suggested in the opinions of ex-Secretary Lane and Senator Wise of the Territorial Legislature, as stated in the hearings:

Mr. WISE. I will come to the next point of my claim, and that is that the Hawaiian people are a dying people. * * * I would like to have the committee just pause for a moment and look back at the Hawaiians, a noble race, who in 1778, according to Cooks' estimate, were 400,000 individuals. Allowing that Capt. Cook's estimate was much too high, the first official census was taken in 1832 and the number placed at 113,319.. The estimated population in 1919 was 22,600 pure Hawaiians and 16,660 part Hawaiians. The Hawaiians were never savages, as I said. They had their system of schools even though they did not have a written language.

The causes of the decline of this race are many. * * * Now, the taro, the Hawaiian food, was the only food they had for generations, outside of sweet potatoes. When civilization came into the country, other kinds of food were brought in. When they

leased their land, the cultivation of taro became scarcer, and they had to pay higher prices to get taro, and consequently the poor Hawaiians had to take what taro they had and mix it with flour and other things, which made the quantity but not the quality.

Right here I would like to take up the time of the committee in explaining the different values of food, the ingredients of food. You take rice. A Chinaman would pick his own rice and say, "Do not give me any Japanese rice, because I would not be able to live on it." And the Japanese would select the Japanese rice, not the same rice that the Chinaman uses. Yet a lot of men could not tell the difference between the two kinds, except that one is stouter. If for centuries the Japanese have not been able to live on the Chinese rice and the Chinese have not been able to live on the Japanese rice, how could the Hawaiians live on this mixed food they get to-day? That, I contend, is why they are deteriorating and becoming extinct. The idea in trying to get the lands back to some of the Hawaiians is to rehabilitate them. I believe we should get them on lands and let them own their homes. I believe it would be easy to rehabilitate them. The people of New Zealand are increasing to-day because they have the lands to live on and are working out their own salvation.

Mr. Dowell. Do they want to homestead these lands and care for them?

Mr. Wise. Yes. * * * The Hawaiian people are a farming people and fishermen, out-of-door people, and when they were frozen out of their lands and driven into the cities they had to live in the cheapest places, tenements. That is one of the big reasons why the Hawaiian people are dying. Now, the only way to save them, I contend, is to take them back to the lands and give them the mode of living that their ancestors were accustomed to and in that way rehabilitate them. We are not only asking for justice in the matter of division of the lands, but we are asking that the great people of the United States should pause for one moment and, instead of giving all your help to Europe, give some help to the Hawaiians and see if you can not rehabilitate this noble people. (Hearings, pp. 38–39.)

* * * * * * *

Secretary Lane. One thing that impressed me there was the fact that the natives of the islands, who are our wards, I should say, and for whom in a sense we are trustees, are falling off rapidly in numbers and many of them are in poverty. They never owned the land of the islands. The land was owned by the King originally, and they had in 1848 what they called a mahele, in which there was a division. As a result of that and legislation that passed subsequently, we have approximately 1,600,000 acres of public lands in the islands. Most of that land is not suitable for making homes. Large bodies of it are lava land or grazing land. Some of it is the very finest quality of land, perhaps 120,000 acres, approximately.

Nobody knows just what the population, the Hawaiian population, was 100 years ago when the missionaries came. Perhaps it was as much as 200,000, probably less. At any rate, now the population is approximately 40,000 of those who have full Hawaiian blood or part Hawaiian blood. In my judgment, from the limited knowledge I have of the history of the islands, those people, the natives, were not treated fairly in the division of the lands that was made in 1848. At any rate, they are a problem now and they ought to be cared for by being provided with homes out of the public lands; but homes that they could not mortgage and could not sell. They are a most lovable people, a kindly people, and a generous people. They have arts of their own which endear them to the people who visit the islands. It is not altogether the beauty of the islands that attracts people there. It is the spirit that they see and the old civilization that they meet. There is a thriftlessness among those people that is characteristic among peoples that are raised under a communist or feudal system. They do not know what the competitive system is and they will get rid of property that is given them. They do not look forward. They can not see to-morrow. Therefore, they should be given as close identification with their country as is possible and yet be protected against their own thriftlessness and against the predatory nature of those who wish to take the land from them, and who have in the past * * *.

Mr. Monahan. And, a second question I want to ask is, What has caused this dying away of the race from 200,000 down to 35,000 or 40,000?

Secretary Lane. Two things. It is always incident to the coming in of civilization, and we always carry disease germs with us to which those people are not immune. Take in Alaska to-day, the influenza and smallpox goes into a village in Alaska and will take one-half of the population. Of course, there are no such ravages in the United States because we, in the course of time, have become somewhat immune to those germs.

Mr. Dowell. And then, too, we are better equipped to care for them.

Secretary LANE. Yes, better equipped to fight, both on the insides of ourselves and outside of ourselves. We have better medical facilities and, of course, we have developed within ourselves a fighting germ in opposition.

No one can say what the fate of a race is. To-day the Indian in the United States is probably increasing. We have 320,000 people of some Indian blood, one hundred and more thousand of those who might be called full-blood Indians. By reason of the facts of putting hospitals on the reservations and doctors and bringing the women when they are bearing children to the hospital, their population is increasing so that we probably have more Indians in the United States to-day than we had during Lincoln's time. And we shall probably have more Indians 10 years from now than we have to-day. These people, the Hawaiians, of course, live an out-of-door life, but they are subjected to the diseases that were brought to them by the sailors a long time ago. * * *

Mr. HUMPHREYS. I was told when in the islands that probably the measles had killed more of them than anything else.

Secretary LANE. Of course that is a very dangerous disease when it is not properly taken care of.

Mr. WISE. If I may interrupt, it was the smallpox that carried off more than any other disease.

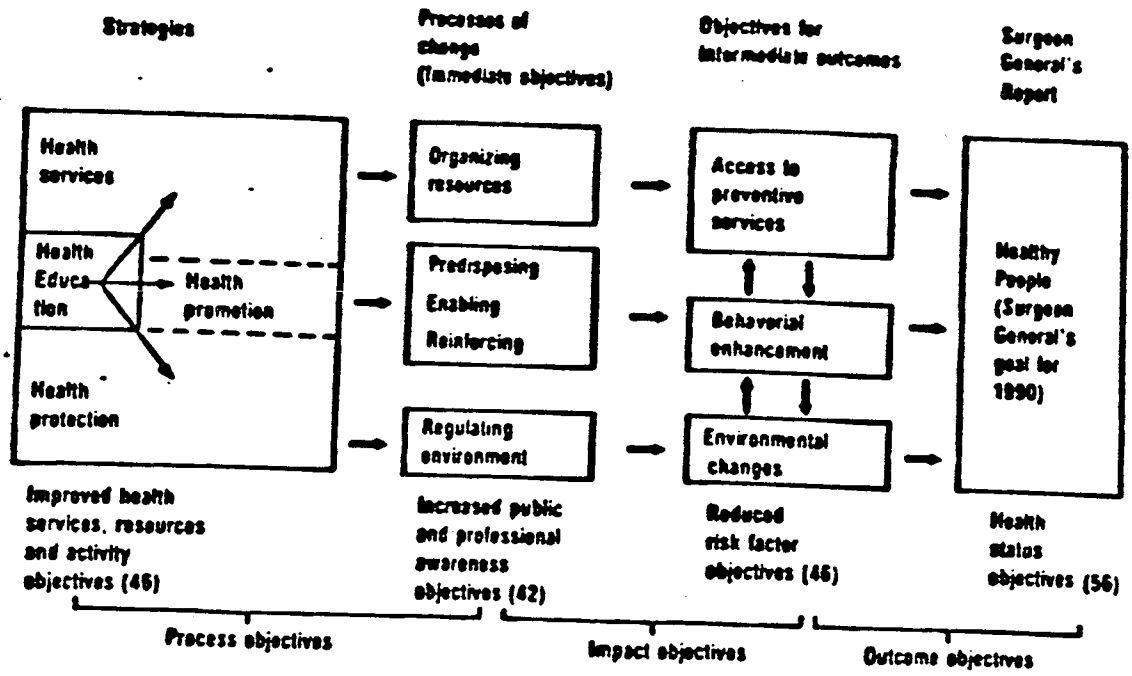
The CHAIRMAN. Is it not true that the measles carried off almost one-half?

Mr. WISE. The measles carried off a big lot of the people, but we lost more from smallpox than from anything else.

(Hearings, pp. 121–2 and 127–8.)

Figure 3

"HEALTHY PEOPLE" - THE NATIONAL MODEL

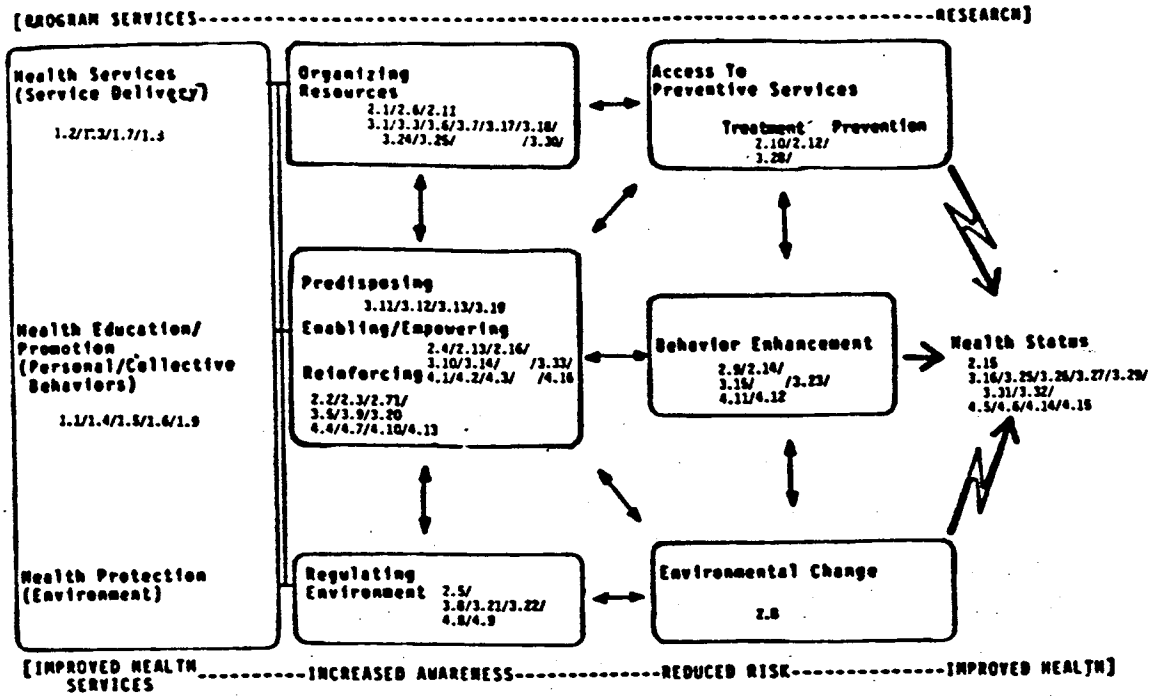


The "Healthy People-Objectives of the Nation" Framework noted above is a graphic representation of a national initiative to set comprehensive achieveable objectives to improve the health status of Americans. The initiative and its objectives cover three main tracks or levels: 1) Health Services, 2) Health Education/Promotion (self-care), and 3) Health protection (environmental concerns). The objectives range from public health practice (services, activities, programs), shown on the far left, to basic research (epidemiology) on morbidity and mortality or "health status," as shown on the far right as "healthy people."

The arrows suggest directions of causal relationships in the framework. The framework is grounded in an emphasis on personal responsibility for one's own health. This is the central principle underlying the operationalization of the framework. In short, the influencing of individual lifestyle change is predicated on the belief that people should take more personal responsibility for their own health whether through services, self-care, or health protection strategies.

Figure 4

"HEALTHY PEOPLE" - THE HAWAII MODEL

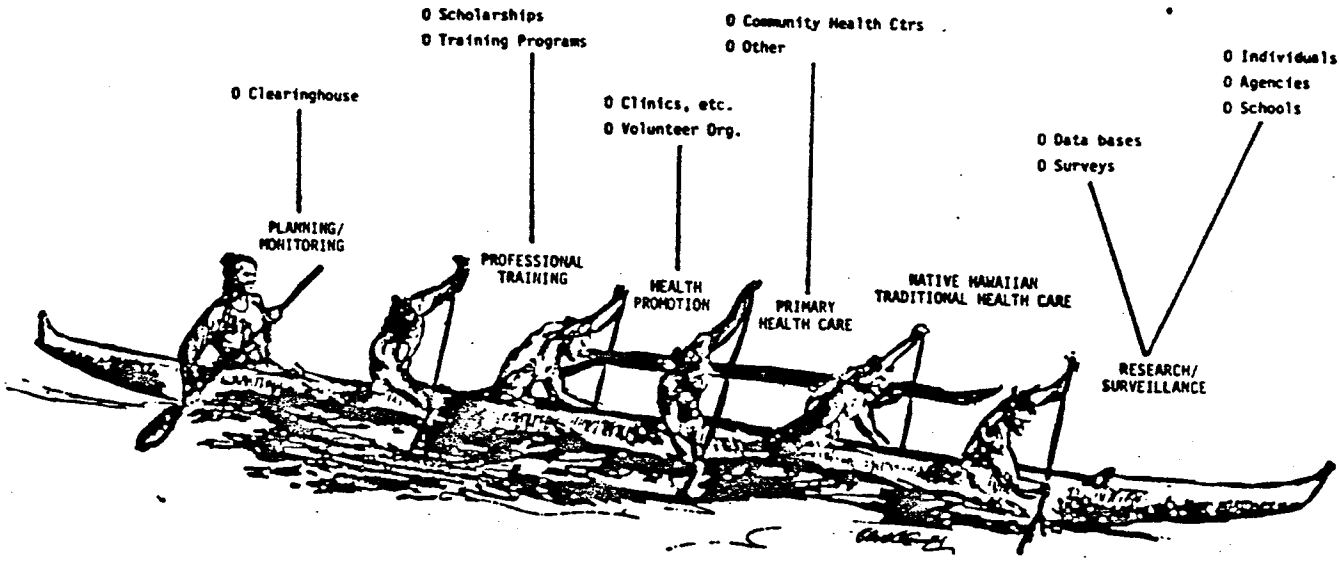


The numbers represented above refer to the various recommendations made by the various task forces.

The Hawaii version of the "Healthy People-Objectives of the Nation" Framework adopts the basic structure of the original model, but moves beyond the model in a number of key ways. Hawaii's Healthy People Framework is grounded in the belief that the major elements affecting one's health are inter-related in many ways; as is shown in the diagram above by the additional arrows making more paths of causality possible. Additionally, the Hawaii framework goes beyond the "personal responsiblity" principle to acknowledge the importance of collective responsibility and community competence in the promotion of health and the prevention of disease. This adaptation liberates a new set of complementary strategies consistent with Hawaiian values and consciousness about community lifestyle and action for health.

Figure 5

Components of a Native Hawaiian
Health Care System



This study's proposed model health care system for Native Hawaiians is similar to an efficiently-functioning canoe crew. The speed with which progress is made is determined by the first paddler who sets the pace for the rest of the crew. The second paddler maintains control and calls out the changes in stroke. He also guides the first paddler and tells him to speed up or to slow down. Paddlers three, four, and five are generally the "heavy weights" in the canoe and provide the power for movement. These folks are especially important if long distances are being traversed. The sixth paddler is the steersman and sets the course of the canoe. He is continually reading the waves and currents and gaging these against the strength of his crew.

Part VI

BROCHURES AND PAMPHLETS

BACKGROUND INFORMATION CONCERNING THE WAIANAE COAST COMPREHENSIVE HEALTH CENTER

JANUARY 1985

HEALTH CENTER ORGANIZATION

The Waianae Coast Comprehensive Health Center is a private nonprofit corporation serving the residents of the Waianae Coast from Kaena Point to Makakilo, including the communities of Honokai Hale, Nanakuli, Maili, Waianae and Makaha.

The Health Center is operated by a community-based Board of Directors who are elected from the membership of the corporation. Membership is open to any resident of the Waianae Coast, or users of services of the Center who are at least 18 years of age. The University of Hawaii Schools of Public Health and Medicine have appointed members on the Board, as does the State Department of Health.

The organizational goals of the Health Center are:

1. To make available to all residents of the Waianae District, complete comprehensive health services including medical, emergency, mental, dental, vision and home health care.

2. To provide these services in an environment that is acceptable to and maintains the dignity of each patient.

The Health Center's primary mission is to provide accessible, quality medical and health care services to a socioeconomically-disadvantaged population on a pay-as-capable basis.

THE PATIENT POPULATION

The primary service area of the Health Center is defined as the geographic area in which more than 80% of its current patients reside (Census Tracts 96, 97, 98). There are 31,487 residents of this primary target area in which resides a predominately low income, Hawaiian population. The three census tracts are federally designated as medically underserved.

The Waianae Coast Comprehensive Health Center realizes 45,000 patient visits annually. There are currently 12,500 registered patients of the Center (patients seen within the last 12 months).

All patients seen at the Health Center are surveyed annually for family size and income. The 1983 survey results show the patient population to be extremely disadvantaged economically. Approximately 67% of the total patient population have incomes of less than poverty level. This compares with a County rate of 9.5% of residents below the poverty level (1980 census data).

Socioeconomic status is further illustrated by reviewing statistics on health insurance of the Waianae population. While only 4.1% of the County population utilizes Medicaid, 40%

or almost 10 times the number of Health Center patients are Medicaid users. While 77.8% of County residents have private health insurance, only 27% of Health Center patients are privately insured.

SERVICES

The services provided by the Health Center are described in Attachment I. The evolving service mix at the Health Center is the result of community long range planning efforts involving over 40 agencies. The Center's emergency room, which provides urgent care at evening and late night hours, is the only emergency room in Leeward Oahu. The late night service was implemented in direct response to the strong demand demonstrated by residents of the Waianae Coast.

STAFFING

The Health Center employs 130 individuals of which 75 are regular full-time employees. The Health Center has attracted a strong, experienced professional staff. Family practice physicians are salaried employees of the Health Center, while medical specialists are contracted employee (with their own malpractice insurance). The Center maintains formal referral relationships with many qualified "in-town" physicians.

QUALITY ASSURANCE

The Health Center has an extensive quality assurance program that features provider case review, medical record audits, and medical director guided remedial actions. A minimum of six quality assurance audits are performed annually, and results are documented in "Provider Orientation Manuals". The Health Center's emphasis on quality assurance has undoubtedly contributed to its continuing positive performance in the area of patient satisfaction.

Hale Ola o Ho'opākōlea*
Alu Like, Inc.
89-137 Nānākuli Avenue • Nānākuli, Hawai'i 96792
Telephone: (808) 668-2361

Hale Ola o Ho'opākōlea/Alu Like, Inc.

Information Sheet

What is Hale Ola o Ho'opākōlea?

- Hale Ola is a cultural healing and counseling program located in Nānākuli.
- It is a special community based project of Alu Like, Inc.
- Objective is to increase the availability of culturally relevant and appropriate mental health services to residents of the Wai'anae Coast.
- Hale Ola provides services to all residents of the Wai'anae Coast.

Services

- Four major Hale Ola activities are:
  1. provide direct counseling services
  2. provide extensive outreach services
  3. work closely with informal community care givers (e.g. those knowledgeable of lomilomi (massage), medicinal herbs, spiritual healers, etc.)
  4. link with various other community agencies and organizations to provide coordinated and complete service to clients
- Hale Ola's staff is comprised of para-professionals who have had experience in outreach counseling work. The majority of them are residents of the Wai'anae Coast.
- In 1982 over 380 Wai'anae Coast residents were served by Hale Ola. They included children, teenagers, adults, and the elderly. Problems included parent child relationships, marital and family difficulties, school related problems, and other situations.
- Hale Ola does not charge for its services. Office hours: Monday, Tuesday, Thursday, Friday 8 a.m. - 4:45 p.m. / Wednesday 8 a.m. - 7 p.m.

*A Hawaiian Cultural Healing and Resource Center

Hale Ola o Ho'opākōlea*

Alu Like, Inc.

89-137 Nānākuli Avenue • Nānākuli, Hawai'i 96792

Telephone: (808) 668-2361

July 5, 1985

Aloha kāua,

Hale Ola Ho'opākōlea, Inc. is a community based organization created as a unique counseling and resource center, located in Nānākuli and presently serving all residents who reside along the Wai'anae Coastline. Hale Ola began in 1981 as a special project of Alu Like, Inc.

So far, Hale Ola has been incorported and has filed an application to obtain our private non-profit 501(c)(3) status [concurrently we are part of the crisis intervention network and continue to meet regularly with our natural helpers. We also meet with our Day Activity Group. The 'Ōpelu Project anticipates receiving a grant for $60,000 from the City & County of Honolulu].

Hale Ola is growing and evolving into a separate entity, but with growth and development comes responsibility and challenges. Because of your expertise and special skills, we wish to invite you to attend the "Hale Ola Ho'opakolea, Inc. Open House Workshops" on:

DATE: Saturday, August 3, 1985

TIME: 10:00 a.m. - 4:00 p.m.

PLACE: Hale Ola Ho'opākōlea, Inc.
89-137 Nanakuli Avenue
Nanakuli, Hawai'i 96792

Refreshments and lunch will be provided.

As an added activity we will also be conducting a tour of the Wai'anae Coastline from 8:15 a.m. - 9:50 a.m. Because space is limited, your response will be required no later than Friday, July 26. You may call Gloria Vincent at 668-2361 with your tour confirmation.

We hope you will be able to contribute your time and energy to Hale Ola. Please RSVP by Monday, July 29, 1985 to Gloria Vincent at 668-2361.

Mahalo nui loa,

Pua'ala McElhaney

Pua'ala McElhaney
Workshop Coordinator

Enclosure

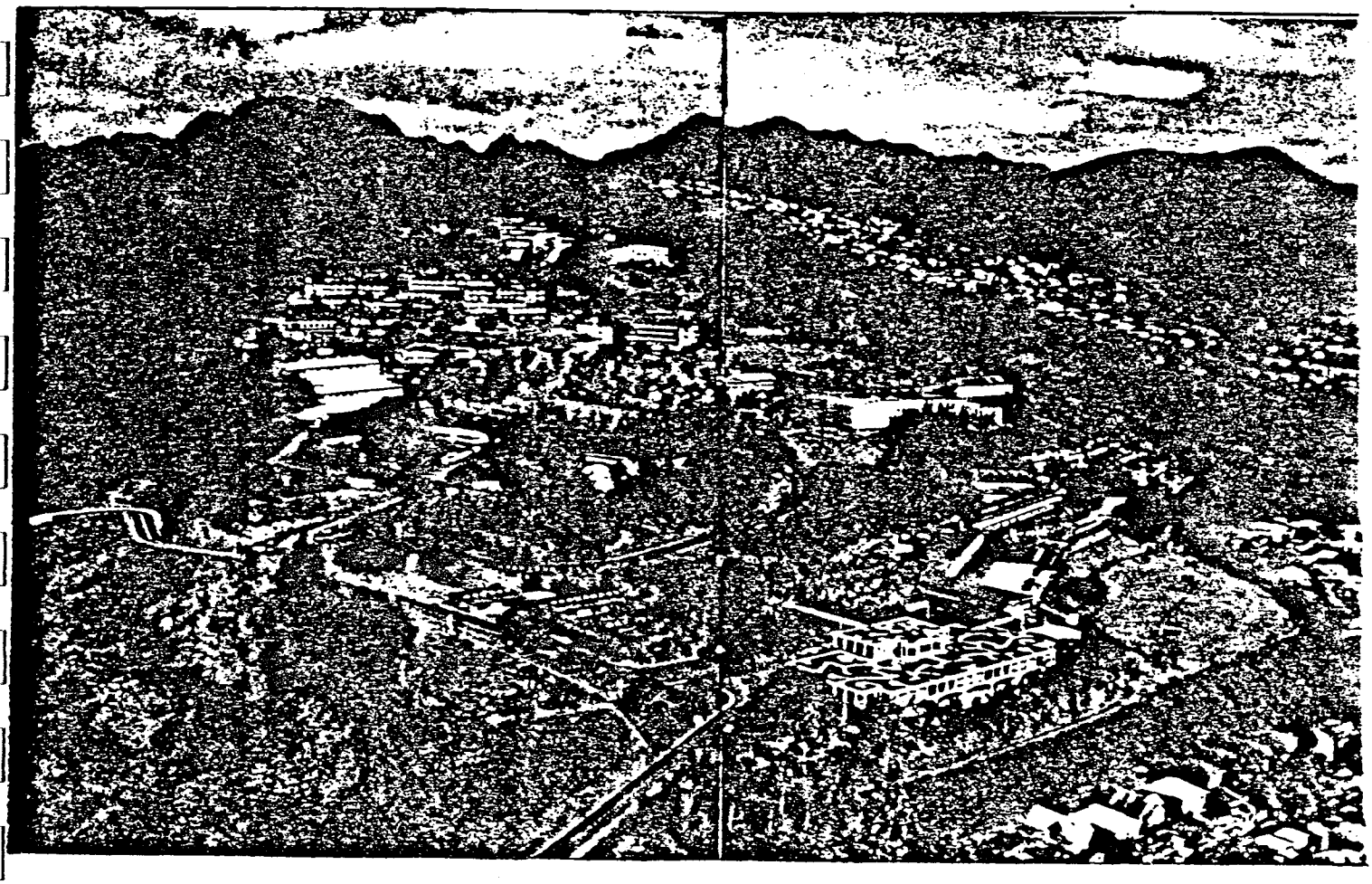
*A Hawaiian Cultural Healing and Resource Center

The Kamehameha Schools

The origins of Kamehameha Schools/ Bernice Pauahi Bishop Estate are rooted in Hawaiian history. Its founder, Princess Pauahi, was the great-granddaughter of Kamehameha the first. Through her legacy, Kamehameha Schools was established in 1887.

The institution has grown dramatically since its founding, and today, its wide range of educational programs and rich traditions touch the lives of thousands of individuals throughout the State.

Kamehameha is one of the most exciting educational institutions in the country. This brochure outlines the educational programs of Kamehameha Schools/Bishop Estate.



Center for Development of Early Education

Kamehameha has gained worldwide recognition for its research in language arts and early childhood education. The Center's work began in 1971 with the Kamehameha Elementary Education Program (KEEP). Its objective was to develop effective ways to help academically at-risk Hawaiian students attain higher levels of educational achievement.

KEEP's success led Kamehameha to expand its research to include educational issues during prenatal/infancy and preschool periods. Approximately 150 children are enrolled in these pre-kindergarten programs and nearly 2,400 elementary students are assisted through work in five Department of Education (DOE) elementary schools and Kamehameha Elementary School. Programs currently include:

PRE-kindergarten Educational Program (0-5 years)

Early intervention programs with parents and children are being developed to better prepare children for school. Current projects include: Kupulani, a home-based parent education program for expectant mothers and families with children up to age three in Hau'ula; a Parent-Child Development Center and Preschool called Ulupono on campus; and four community preschools operated in cooperation with the DOE. The preschools are located at: Nānāikapono and Nānākuli Elementary Schools on O'ahu, Waihe'e on Maui, and Anahola on Kaua'i.

Kamehameha Elementary Education Program

The Center's researchers have developed a language arts program proven effective with Hawaiian children who have performed below national norms on standardized reading tests. KEEP's methods are being disseminated to five public schools through teacher training and consultation. These five schools are located in Keaukaha and Pāhoa, Hawai'i; Kekaha, Kaua'i; and Nānāikapono and Wai'anae, O'ahu.

In addition, KEEP methods and curriculum are used in the Kamehameha Elementary School (KES) on campus. Students are all of Hawaiian ancestry and are representative of the general community in educational background and aptitude.

Extension Education Division

Post-High School Programs

Continuing Education Program

The Program is made up of three major components:

The Adult Basic Skills Interagency (ABSI) achievement model is offered at Kapālama, Kahalu'u and Punalu'u on O'ahu, Kualapu'u on Moloka'i and Puakukalo on Maui. Several educational, community, social and Hawaiian agencies work together to plan and deliver these educational services.

Adult Evening Classes on campus include 'Ohana Education, Hobby, Career and Work Skills and computer classes. 'Ohana Education curriculum gives families the opportunity to learn together.

The Hawaiian Culture Lecture Series is offered at 12 community sites State-wide. Topics include Hawaiian culture and history.

Nā Ho'okama A Pauahi Scholarship Program

The scholarship program provides academic counseling, career guidance and assistance in locating other financial aid opportunities to students throughout the State. Nā Ho'okama staff work closely with financial aid officers and counselors from public and private educational institutions throughout the State.

Annually $325,000 is granted to public and private high school graduates of Hawaiian ancestry who continue their education at any college, business, or vocational training institution in the State.

The Nā Poki'i Scholars Program awards funds totaling $35,000 to students who pursue advanced degrees in medicine, law, education, social work, engineering and geophysics at the University of Hawai'i, Mānoa.

From:

He Aha Ka Mea Hou Ma Kamehameha, Vol. 18, No. 4, May-June, 1985, p. 15.

Alumni Profile

Alumna one of many Imi Ho'ola beneficiaries

Chiyome Fukino (KS '68), a graduate of Imi Ho'ola, has launched a successful career in medicine.

A little over a decade ago, the number of Hawaiians who were primary health care professionals was less than 15.

The University of Hawai'i Medical School had just become a four-year program, after operating as a two-year program for five years.

Medical School Dean Terence Rogers noted that Hawaiians were under-represented in the health care community, and in 1972, he assigned the task of developing a program to address this concern to Dr. Benjamin B.C. Young.

Part-Hawaiian himself, Young was sensitive to Hawaiian problems and involved in the Hawaiian community. The bottom line for Young was to get more Hawaiians and South Pacific minorities into medicine.

Young made some initial assumptions, which included the belief that many minorities did not enter the medical field because they were not sufficiently prepared to meet the rigorous entrance standards set by medical schools. He came up with a program designed to provide an intensive year of review in pre-med courses.

It took a tremendous amount of planning, coordinating and forethought to develop such a program from scratch. Literally, everything had to be secured or developed, from rooms to pencils, telephones to typists, slides to skeletons; not the least of which were faculty and the curriculum.

One year later, the program called Imi Ho'ola, "Those Who Seek to Heal," began with 20 students.

The program is designed to upgrade the skills of men and women from Pacific Basin areas who wish to enter the field of medicine so that they may be competitive with other groups vying for medical school. But it goes beyond that; it provides the opportunity to consider a medical career in a supportive environment.

Internist Chiyome Fukino (KS '68), a member of Imi Ho'ola's initial class says, "Unless you're in a physician's family, you don't know what's involved in being a doctor. Imi demystified the profession for me and showed me that what's involved is a lot of hard work and commitment."

Over the years, Imi Ho'ola has strived to meet the changing needs of a diversified community. It presents alternative careers in medicine for those students who recognize that perhaps being an M.D. is not a viable option.

Nanette Mossman Judd, R.N., M.P.H., (KS '62) who serves as a counselor and instructor in the program says, "Most of our students come from disadvantaged backgrounds. A big road block for them is building self-confidence, going from 'I think I can,' to 'I can do it.' We teach them time management skills, analytical skills, and last but not least, we stress commitment."

A clear indication of this confidence and commitment is the success of Imi Ho'ola students who make it into medical school. Thirty-five men and women have become physicians as a result of this program and another 39 are currently enrolled in training.

"We give students an opportunity which they might not have otherwise received, but the rest is up to them," says Young. □

OPPORTUNITIES IN MEDICINE
for PACIFIC BASIN YOUTH

For full details contact:

MARILYN M. NISHIKI
STUDENT SERVICES SPECIALIST

BENJAMIN B. C. YOUNG, M.D.
PROJECT DIRECTOR

OFFICE OF STUDENT AFFAIRS
1960 EAST-WEST ROAD
HONOLULU, HAWAII 96822
TELEPHONE: (808) 948-8300

An apprentice learned the art of diagnosing by practicing on pebbles which a kahuna laid out on a mat in the form of the human body. A pupil learned in this way how to feel out with his fingers the symptoms of various illnesses. Some 480 white, red, and black pebbles arranged in the shape of a man represented some 280 diseases. When a student had become thoroughly familiar with abnormalities as represented by the pebbles, he was allowed to perfect his technique by practicing on the sick.

Courtesy Bishop Museum Press
HAWAII - A PICTORIAL HISTORY

JOHN A. BURNS SCHOOL OF MEDICINE
UNIVERSITY OF HAWAII
1960 EAST-WEST ROAD
HONOLULU, HAWAII 96822

THROUGH **IMI HO'OLA**
"THOSE WHO SEEK TO HEAL"

KULIA
"STRIVE TO REACH THE SUMMIT"

MEDICAL CAREERS FOR PACIFIC BASIN YOUTH
Hawaiians · Filipinos · Samoans · Micronesians AND OTHER American Pacific Islanders

The non-competitive and unaggressive nature of most Pacific area cultures often imposes a hardship on Pacific Island students who find themselves unprepaped for the harsh rivalry traditional in western educational situations. Special help is sometimes necessary to assure that promising medical careers are not aborted or detoured into unrelated fields. These programs are designed to lend that needed support.

1. IMI HO'OLA "Those who seek to heal"

We have a program geared to provide particular requirements of Hawaiians, Filipinos, Samoans, U.S. Nationals in American Samoa and the Trust Territory.

- If you have taken Pre-med but were not accepted in medical school due to intense competition
- If you have a degree in a paramedical or related field (pharmacy, biology, oceanography, etc.) but now work in a non-related field
- If you have entered college and are now a senior majoring in a science field
- If you have a potential to enter medicine but have been hindered by a disadvantaged background or other obstacles through no fault of your own ----

IMI HO'OLA MAY BE YOUR OPPORTUNITY. Twenty students are accepted each year for an intensive premedical review consisting of:

- A thorough review of pre-med Biology, Chemistry, Mathematics and Physics.
- An evaluation of your strengths and weaknesses provided through extensive testing and training. The purpose is to improve learning effectiveness and to diminish the impact of social or cultural shock.

THERE ARE NO GUARANTEES FOR ADMITTANCE TO MEDICAL SCHOOL, but our goal is to assure your qualification for admittance.

2. KULIA "Strive to reach the summit"

WE HAVE TEN OPENINGS AVAILABLE FOR AMERICAN PACIFIC ISLANDERS. KULIA provides a special tutorial program in the basic medical sciences.

TO QUALIFY:
- You must have completed 3 or 4 years of college with particular emphasis on the basic sciences.
- You must demonstrate a socio-economic or educationally disadvantaged background.
- You must meet all the rigid requirements for entrance to medical school. Standards for admission as a candidate for the M.D. degree are high.
- You must have an exceptional desire and motivation toward a medical career.
- You must be prepared to work hard, for long periods without respite.

TO SUM UP..

IMI HO'OLA is an intensive remedial year in basic pre-medical science, designed to upgrade promising men and women who for reasons beyond their control may not be sufficiently qualified academically but who show great promise in other respects. The intent is to develop these students into highly competitive applicants for admission as M.D. candidates.

KULIA is, in a sense, an extension of Imi Ho'ola into the medical curriculum itself. It is designed for less well prepared students who are given tutorial assistance in the basic medical sciences.

Both of these programs are aimed at opening medical careers to young men and women, primarily from those groups generally underrepresented in medicine, who, in their academic careers, have had to overcome significant hurdles arising from their socio-economic and educational situation. Opening the ranks of medicine to representatives from these groups serves both social justice and to enrich the profession itself.

CHAPTER V
Culture Loss and Stress Among Native Hawaiians

"Na kanaka 'oku'u wale aku no i kau 'uhane"
"The people dismissed freely their souls and died."

— Hawaiian saying cited in Young, (1980)

Cataclysmic cultural change, the kind of change which can lead to the loss of the very will to live, has occurred in Hawaii. Earlier in this report we described the ecological model of Bronfenbrenner (1979) which includes the concept of "transforming experiment:" the "systematic alteration and restructuring of existing ecological systems in ways that challenge the forms of social organization, belief systems, and lifestyles prevailing in a particular culture or subculture" (p.41). The islands of Hawaii have been thrust into the modern world in a series of such transforming experiments. As the theory points out, changes at the macro-system level will produce changes at the individual and family levels as well. It is the meaning of this upheaval in Hawaii, its implications for the daily lives of modern Hawaiians, which concerns us here. Has massive change caused a loss of culture so severe that a chronic kind of depression exists among modern Hawaiians? Could this account for lowered academic performance and other negative outcomes for Hawaiians?

This has been a recurring theme among writers and observers of the social and cultural context of modern Hawaii. In the book *Strangers in their own land: Self-disparagement among ethnic Hawaiian youth* (1972), Donald McNassor and Randall Hongo write:

> The fear in Hawaiians of losing ethnic identity is well known. There is deep concern over the loss of language, traditions, skills. One Hawaiian school teacher expressed it sadly to us thus,"I fear the Hawaiians will soon exist as a cultural entity no more. The sentiment is so open and prevalent, it does not have to be documented by extensive research." (p.18)
>
> The Hawaiian youth in this study feel a sense of alienation. They feel alienated from the majority Japanese culture with its emphasis on higher education, artistic achievement, business entrepreneurship, and political influence. They feel alienated from the corporate Caucasian enterprises that surround them. That world simply does not have any future for them in their minds except as laborers or service personnel. The thought of one day being among upper levels of management in one of the major hotels or in agriculture is inconceivable to them. They constantly refer to themselves as people whom other groups consider to be intellectually inferior in academic performance, happy-go-lucky and uninhibited, destined to use their hands, not to develop their heads. (pp. 10-11)

It is these kinds of feelings of inferiority, sadness, and depression which have been hypothesized to underlie the negative social, economic, and educational statistics of Native Hawaiians. For example, Myron Thompson, Trustee of The Kamehameha Schools/Bernice Pauahi Bishop Estate, recently offered the following analysis in interviews with reporters:

> Based on his experience as a social worker, Trustee Thompson said he believes that deeply ingrained feelings of cultural inferiority are partly responsible for Hawaiian children averaging below state and national norms academically.
>
> 'Since (Captain James) Cook landed, there have been a lot of putdowns for Hawaiians, and you still see the dregs of it today. Where does it get started? At birth. In the family' (Titchen, 1982 p. A-6).
>
> 'We Hawaiians are an enigma,' says Myron B. Thompson ....
>
> 'We are fascinated by our history, though much of it is nightmarish. We are a compassionate people, fiercely proud of our cultural heritage, and we are outraged to see our fragile physical setting — our

FROM: The Kamehameha Schools/Bernice P. Bishop Estate, Final Report, Native Hawaiian Educational Assessment (pages 203-213).

tropical waters, mountains, air, flora, and fauna — being polluted and trampled to death by civilian in-migrants, whose numbers have tripled in the past decade. As a result, too many Hawaiians have a low self-image, Thompson adds. Too many function in a constant state of depression. This state of mental ill-health results in social failure, delinquency, unemployment, and unrealized potential.' (Shaplen, 1982, p.57)

Others have written and testified of similiar feelings:

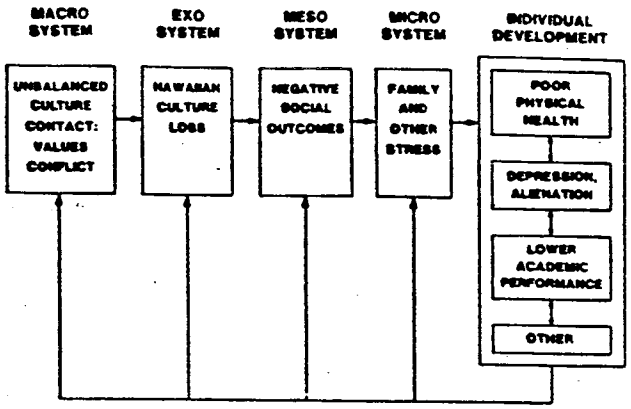
> I come before you today as a young Hawaiian, sincerely seeking constructive ways to remedy the past and redirect the present day plight of Native Hawaiians. The history of the Hawaiian people shows the unjust abrogation of their lawfully constituted government, the unlawful seizure of ancestral lands without compensation, the stripping away of their sovereignty, and the imposition of a more dominant Western culture. A sad feeling of hopelessness and powerlessness followed (late 19th and 20th centuries). Widespread demoralization and disintegration of Native Hawaiians is demonstrated by present day social, economic, and educational statistics. (Keoni Agard, Bill 916 p. 91)
>
> The contemporary problem facing the Hawaiians is a feeling of abnormality in their own homeland, of being at the bottom of the educational and economic heap. (Ogawa, *Honolulu Advertiser*, December 20, 1971)
>
> There is a feeling of hopelessness among most kids. (Henning, 1978a, p. 22)

The recurring theme, then, emphasizes self-disparagement, feelings of inadequacy, fear of failure as well as fear of success, alienation, hopelessness and helplessness, depression. How is this related to academic disparity?

The Culture Loss/Stress Hypothesis

In its simplest form, the Culture Loss/Stress Hypothesis posits the existence of a set of maladaptive behavioral predispositions among modern Hawaiians. This syndrome is hypothesized to relate to the rapid and severe culture loss experienced by Hawaiians since the advent of "western" culture, beginning with the discovery voyages of Captain James Cook in 1778. The syndrome itself is held to include lowered school performance among Hawaiian children and, thus, indirectly as well as directly contribute back to negative social outcomes for Hawaiians. The following diagram graphically depicts this causal chain idea: Implicit within this notion is a feedback loop

FIGURE 32
THE CULTURE LOSS/STRESS HYPOTHESIS



which makes the cycle self-perpetuating. That is, without intervention, one would expect further cultural disparity, further culture loss, more depression, and increased social failure over time.

Other Chapters of this report have documented some of these concepts more fully. Chapter II, for example, showed that while laudable gains have been made, lowered academic performance and negative social outcomes continue to be characteristic of the Hawaiian student population. Chapters III and IV presented evidence from a wide variety of sources showing that there was historically an unbalanced culture contact and negative social outcomes for Hawaiians. It is the linking concept of depression which will be more fully examined here. Several key questions raised by the Culture Loss/Stress Hypothesis will be considered:

1.) How were the historical changes of the past two centuries in Hawaii experienced as culture loss by the individual Hawaiians?
2.) What is stress? Can the experience of culture loss cause it? Can it affect academic performance?
3.) What aspects of stress can be found among modern Hawaiians?

The Chapter will conclude with a discussion of

what further investigation needs to be done in this area.

1.) **How were the historical changes of the past two centuries in Hawaii experienced as culture loss by the individual Hawaiian?**

Historians agree that profound changes have indeed occurred in Hawaii since the arrival of Captain Cook in 1778. Social scientists who study acculturation point out that any contact between two cultures will inevitably result in some changes for at least one of the cultures. To the degree that one culture is perceived as more powerful or influential, changes will favor that culture. Usually the process of change involves some degree of alteration in **both** cultures-in-contact. Even cultures in relative isolation change over time. Clearly, for example, "western" culture today is a far cry from that of Captain Cook's time. So the inference of culture "loss" must be carefully made. It must be distinct from simple cultural change to accomodate changing environmental contingencies.

The weight of testimonial data (Chapter IV) strongly supports the notion that many aspects of Hawaiian culture have indeed been lost. Leaving for the moment the "responsibility" for the loss, it seems clear that what was felt and experienced by Hawaiians and non-Hawaiians alike was the systematic suppression of many Hawaiian forms, including language, religion, values, economy, ruling system, and way-of-life. Indeed, the Hawaiian population itself was reduced and almost lost due to introduced disease. Some suggest that this pattern was the result of conscious colonial intentions on the part of foreigners: that Hawaiians were "ripped off:"

> The history of the Hawaiian people saw the unjust abrogation of Hawaiian national sovereignty, the progressive dispossession of Hawaiians from their land, a dramatic reduction of their numbers through disease, and a progressive dilution of Hawaiian culture. (Daniel Inouye, Bill 916, p. 32)

Others point out that the Hawaiians were striving to make the best of a situation leading to inevitable change:

> With their talent for initiating and accepting change, the Hawaiian people were able to adopt, within a comparatively short time, the avalanche of novel things and ways introduced by the Europeans. As the foreigner exalted the worth of his own ways and deprecated the native ways, the Hawaiian people were persuaded to accept basic changes in their life style and as a result lost confidence in the worth of their own culture. (Mitchell, 1969)

Others simply describe the process of loss:

> Gradually Hawaiians concealed their practice or forgot their knowledge of much of their ancient culture. What was remembered would be recalled with increasing distortion. For when a specific practice was discarded or forgotten, there went with it the enduring, often wise concept from which the practice evolved. (Pukui, Haertig, Lee, and McDermott 1979, p. 303)

While there is consensus that a major loss of culture occurred, it is worth noting that this was clearly not total cultural loss. To some extent this is self-evident: there would be no interest in cultural revival today if there were no individuals with knowledge of the culture left. Why some cultural forms were able to survive (chant and dance, for example) while others were not is a study in itself. It should also be pointed out that the modern culture of Hawaii represents changes in "western" thinking which were profoundly influenced by contact with Hawaiian culture. On balance, however, it is safe to say that there was more of an experience of change and loss among Hawaiians over the past two centuries than there was such an experience by "foreigners." It is often remarked that others came to Hawaii from other homelands, whereas the descendents of the inhabitants of these islands regard them as their only homeland, one that has been overrun.

The question remains, however, of how the **individual** comes to realize or feel that something is missing or has been unfairly taken away. In some documented cases it is as direct as a parent telling a child that he or she should not learn to speak Hawaiian, implying that there is something wrong with a part of that family's background. In other cases is seems to be more of a slowly growing perception of something wrong. Consider the following individual cases:

'I started out with mixed feelings. I went to Kam Schools and I was proud of that. I studied *hula* — authentic *hula* — and I was proud of that. And at home my father would tell us Hawaiian riddles and stories, but he stopped at that. When it came to anything else, beliefs or old customs, he would tell me — over and over — "Leave Hawaiian things alone. You've got to grow up *haole*."

By the time I went away to college, I wasn't consciously Hawaiian at all. My mainland classmates accepted me. I had lots of friends. But they began pointing out differences in me. They thought I was unusually helpful. I told them about *kokua*. They began to ask all kinds of questions about the way I lived. And for the first time I realized that I *was* different, and I liked the difference. I began to appreciate what I left behind me. So I came home to finish college.'

Home again, Leila began to study Hawaiian at the University of Hawaii and joined Hawaiian study and social groups. . . .

'As for me, somewhere along the line a connection was made. For a long while, even after I began to study the Hawaiian language and culture, I thought of myself as segmented. Part of me was *haole*, that part got a graduate degree. That part got ahead. Another part of me was Hawaiian. That part was helpful and warm. But then, finally, the two came together. They are both me.' (Pukui, Haertig, Lee, and McDermott, 1979, p.313)

'My daughter was so close to my non-Hawaiian in-laws that she thought we Hawaiians were silly. She'd say to me, "Mama, Hawaiians are nuts." Then I took her to Ni'ihau for a visit and she got an idea of the old culture. She said to me, "Mama, these are really nice people. What happened to the people on the outside?" I said, "They (other Hawaiians and part-Hawaiians) are mixed up. You mention something as wonderful as *mihi* and *kala* (forgiving and releasing from bad feelings) to them and they say, 'Oh, leave that alone. That's kahunaism.'" (Pukui, Haertig, Lee, and McDermott, 1979, pp. 312-313)

These represent "success stories" in that the individuals faced and apparently overcame the forces which were tending to denigrate the Hawaiian aspects of their heritage. Others were not so fortunate:

Among the Center's (Queen Liliuokalani Children's Center) deeply troubled clients, self-concept as being Hawaiian tends to be negative. Nearly every misfortune or failure is equated with being Hawaiian:

'The reason all this trouble happens to me is that I'm Hawaiian. There's nothing good about Hawaiians.'

'It's this way (on welfare) with us because we're Hawaiian. It's not this way with other people.'

A Chinese-Hawaiian boy in trouble with the law: 'It's the bad Hawaiian in me. Why are you trying to help me? I'm a bad Hawaiian kid.'

'I act this way because of my bad Hawaiian blood.'

'We didn't give the baby a Hawaiian name. That way, maybe all the badness of being Hawaiian won't go to him.'

'My in-laws (non-Hawaiian) think I'm just a stupid Hawaiian.' (Pukui, Haertig, Lee, and McDermott, 1979, p.308)

Perhaps no other single event represented "loss" more to Hawaiians, both figuratively and in a sense relatable to everyday life, than the overthrow of the monarchy in 1893 and subsequent annexation to the United States of America. Most modern Hawaiians were not alive then, but many grandparents and great-grandparents were, and the stories do get passed along. And the feelings were very real and very strong.

About seventy years after annexation at a schoolhouse meeting in Kaaawa, the subject of aloha was being discussed by a mixed racial group. A Hawaiian told of his experience at age seven with the Provisional Government's police force, adding that the republic was a police state then. He remained true to the Hawaiian government till today. (Agard, 1982, p.46)

Concerning this period of time, historian Lawrence Fuchs wrote,

The essential purpose of the haole elite for four decades after annexation was to control Hawaii; the major aim of the lesser haoles was to promote and maintain their privileged position. Most Ha-

waiians were motivated by a dominant and inclusive purpose ... to recapture the past.

The present and future appeared devastatingly bleak to the Hawaiians, who continued to decline in numbers due to social disorganization, psychological demoralization, susceptibility to disease, and intermarriage. (Fuchs, 1961, p.68)

There were many individual kinds of responses to events like annexation. One was the active seeking of the culture of the past:

On the Windward coast of Oahu, in the village of Punaluu, visitors to Hawaii in the 1960's sometimes met a strikingly handsome man, about five feet eleven, whose bronzed and muscular figure was clothed about his loins with the traditional Hawaiian *malo*, this one made of red cloth. David Kaapu, except for his coconut hat and big cigar, was the prototype of the Hawaiian aborigine described in early literature. Vigorous, alert, industrious, full of humor, and hospitable, this philosopher prince of Punaluu brought to life images of the strong men who swam nearly naked to greet the earliest whalers and trading vessels. He was trying desperately to be faithful to the old ways and said, more with sorrow than bitterness, that he had been destroyed even before he was born. (Fuchs, 1961, p.8)

Others simply hid their feelings or withdrew:

By withdrawing, many Hawaiians kept the haoles from learning how they really felt. But high society hapa-haoles in town could not withdraw. They could only veil their true feelings. One of these, a daughter of one of the last princes — a secret guarded from even her closest haole friends — overstated it this way on the eve of statehood: 'Every Hawaiian holds in his bosom a longing for the monarchy and a deep distrust of the haoles, but our cause is hopeless. What can we do?' (Fuchs, 1961, p.82)

So, presumably, many times over in many Hawaiian households, deep ambivalent feeling became expressed through suppressed hostility towards "haoles," "missionaries," and others, through subtle withdrawal from participation in social opportunities, through hiding of cultural practices, through grudging emphasis on the need to become haole. There are no studies which have measured this phenomenon, but it is not difficult to infer the potential effect on the lives of individual modern Hawaiians.

It may be concluded, then, that the events called "culture loss" have had, and continue to have, effects on the lives of individuals at all levels of the ecosystem. Are these effects contributing to educational problems? If so, how, and with what other outcomes?

2.) What is stress? Can culture loss cause it? Can it effect academic performance?

There is a growing body of research and literature showing that human beings share with other living creatures an innate physiological mechanism designed to protect them from harm. This mechanism reacts to threatening external events by arousing the organism into a state which has been called "fight or flight." The **stress response**, while designed to protect, can itself be injurious to the organism if excessive and unresolved. In other words, **chronic** stress can lead to many forms of physical and mental collapse (Selye, 1956).

The stress concept is not a "diagnostic" one, but rather an explanatory one: chronic or traumatic stress can lead to any number of symptoms including physical disease and behavioral pathology. As such, stress is a "non-specific" concept: in and of itself it does not predict what personal system will experience breakdown, just that breakdown will occur somewhere. Because it relates to the **body** as well as the mind, it implies that where chronic stress exists one would expect to find higher instances of all kinds of disorders. The **form** of the disorders, then, would have to be explained by reference to the culture and individuals in question.

Cross-cultural researchers point out that symptomatology and the experience of mental illness differ dramatically across cultures. Some mental disorders are unique to certain cultures:

Pibloktoq, or arctic hysteria, is found among certain Eskimo populations and is characterized by anxiety, agitation, amnesia, and fear. Oftentimes the victims will take off all their clothes and run naked in the snow. (Marsella, 1979, p. 247)

In Marsella's (1979) review of the cross-cul-

tural study of mental disorders, he points out that culture has multiple effects on both the occurrence and expression of mental disorders. This is because cultures will inevitably differ in their definitions of "normality" and "abnormality," in their susceptibility to different kinds of stress inducers, and in their variations in personality. The rapid culture change or culture loss situation is seen as a significant contributor to individual and family stress. Similarly, feelings of inadequacy or low self-esteem would be expectable when an individual is, for example, trying not to teach her children her own native language but another language instead.

Marsella (1979) lists seven areas in which cultures themselves have been found to be the agents inducing stress in individuals:

1.) **Value Conflict Stress.**
Conflicting values within a given society.
2.) **Social Change Stress.**
Urbanization and modernization can challenge existing means of adapting.
3.) **Acculturation Stress.**
When two different cultures come into direct contact with each other.
4.) **Life Events Stress.**
Events such as divorce, joblessness, etc., vary in frequency across cultures.
5.) **Goal-striving Discrepancy Stress.**
In cultures fostering overly high achievement aspirations.
6.) **Role Discrimination Stress.**
Status discrimination places pressure on lower-status groups.
7.) **Role Conflict Stress.**
Individuals in some cultures have to assume multiple, sometimes conflicting, roles.

Clearly, all of these types of stress, and the overlapping between them, have afflicted the Hawaiians since the first contact with "western" cultures. If these kinds of culture-induced stresses actually do have psycho-social results as suggested here, then one would expect to find similar patterns among other cultures who have experienced similar acculturative or social change events.

Pelletier (1977) presents several such cases. For example, the effects of rapid social change in central India is reported:

> There was increasing upward mobility for a number of Indians living in this area. They were relatively affluent, well nourished, hygienically oriented, educated, and Westernized. In the larger communities, their living conditions were far superior to those of their compatriots living in villages and city ghettos where people were overworked, underfed, uneducated, and not attentive to hygiene. Yet it was among the wealthier Indians that such diseases as diarrhea, ulcerative colitis, neurocirculatory asthenia, and asthma were increasingly prevalent. They were overtaxed by the necessity of adjusting to new values and new circumstances, since they were caught between two social systems and did not find security in either one. Their reactions to this period of excessive change caused them to be tense and anxious, and to exhibit both offensive and defensive protective patterns of behavior. Based upon these observations, Wolff concluded that these people were under constant stress, and that this contributed to their high incidence of psychosomatic disease (Wolff, 1968).
>
> Similarly, Navajo Indians taken from their homes and put onto reservations only a few miles away suffered an appalling increase in mortality from tuberculosis after they had moved (Moorman, 1950). Although the new physical environment was nearly identical to that from which they had come, and circumstances such as food, clothing and hygiene were the same or better, the social disorganization which resulted from the move overburdened the adaptive capacities of many of these Navajos, and they became ill. (pp.84-85)

In the opening section of this chapter we noted the prevalence of a theme characterizing Native Hawaiians as having feelings of hopelessness, despair, inadequacy, self-doubt. These feelings are strongly suggestive of what western psychology and psychiatry call "depression." The term depression has itself been used to describe the Hawaiian condition. Do these concepts relate to the educational needs discussed in the earlier chapters of this report?

It is clear that depression can be conceptually related to lowered academic performance, in

fact, in the clinical definition (Diagnostic and Statistical Manual of Mental Disorders III, American Psychiatric Association, 1980) "decreased effectiveness in school" is one of the key behavioral symptoms of depression. There is some debate over whether behavioral disturbance in children is a direct manifestation of depression or simply "masks" its presence. For example, Hollon (1970) offered the following conclusion in his discussion of poor school performance:

> Depression in children has received little attention but it is more common than is generally assumed, although it is often masked by other forms of behavior disturbance. A number of children initially referred for psychological testing because of poor school performance were found, upon evaluation, to be suffering underlying depression which was the true source of their school failure. (p. 263)

He also offered the following perspectives on symptomatology and intervention:

> ... features which can be best described as depressive are definitely evident in feelings of inadequacy, feelings of worthlessness, conviction of rejection by others, and guilt, along with helplessness and hopelessness which undermines all effective effort. (p. 258)

A similar perspective was presented by Friedman and Doyal (1974), whose article also noted the role that social and cultural influences can play in the development of childhood depression.

> ... Social and cultural influences also must be considered for their possible contribution to the etiology of childhood depression. Low self-esteem, feelings of helplessness, and ultimately apathy derived from an image of the self as helpless in the face of social and environmental structures assuredly must play a contributing role in depression, particularly among culturally deprived and minority group members. (p. 22)

3.) What aspects of stress can be found among modern Hawaiians?

In the case of Hawaiian youth the descriptions offered by social scientists with the KEEP project of students attending the lab school certainly do not match the classic image of depression — the morose, withdrawn individual who has little energy to expend on daily activities. In fact, the exact opposite picture has been painted, as the following excerpt suggests:

> As a group, Hawaiian children are vigorous, socially skilled, talkative, affectionate, and aggressive. None of these traits are surprising; they arise naturally from the peer and sibling-oriented culture. But these traits as manifested in an ordinary classroom can produce chaos; when viewed by a frustrated teacher, they are described in far less complimentary terms, such as 'rowdy, restless, inattentive, lazy, uninvolved, provocative.' (Tharp, 1977, page 16)

It must be emphasized that these observations are not those of the "ordinary classroom" teacher. They point out once again how the viewpoint or cultural perspective of the observer is of critical importance in the determination of what is "normal" and what is not.

The beginnings of self-deprecatory behavior may not appear until later in schooling. McNassor and Hongo (1972) point out that:

> Two exploratory studies suggest that Hawaiian children may not feel inferior in academic capability in the elementary school. To the contrary, they show a decidedly strong feeling of academic competence and self-worth. They consider 'haoles' and Japanese inferior to them in terms of being smart in school, in reading, using standard English, using pidgin English, arithmetic, P.E., singing, physical strength, and so on.... In the sixth grade, the year prior to junior high school, the children began to express doubt about their academic capability. (pp.5-6).

Certainly if the behaviors described in this summary overview of the Hawaiian child in school are manifestations of an underlying depression, one would have to label them "masked," for they hardly create an image of pervasive depression.

At the same time, however, the point could be made — and it has been, (e.g., Lefkowitz & Burton, 1978) — that developmental variables greatly complicate any discussion of depression among children. For example, behaviors

that might be considered indicative of depression at one age may be well within normal limits at another. Thus, it is not inconceivable that the vigorous primary students described above may, after years of teacher disapproval and other aversive consequences, experience feelings of depression that will interfere with their school performance.

Watson (1977), has made the point that "interference effects," or to use the more commonly recognized term "learned helplessness" (cf. Seligman, 1975), can arise when uncontrollable or "non-contingent" stimulation is neutral or even apparently helpful. His research on infant learning suggests that depression, listlessness, and general lack of motivation may result from rearing conditions that provide an abundance of non-contingent input or experience combined with limited experiences in which behavior is responded to contingently. He outlined briefly how a growing middle-class emphasis on "stimulation" of babies might produce undesirable results if this stimulation is largely independent of infant actions.

The connection with Hawaiian circumstances here revolves around the issue of child-rearing practices. For example, Sutton-Smith (1977) has noted that peer caretaking, apparently common in Hawaiian families (Weisner & Gallimore, 1977), might be reconsidered in light of what research has shown to be the "positive" (from a dominant cultural perspective) outcomes associated with attentive maternal care. His point was: siblings are probably not as sophisticated in their responsiveness to young children as a parent might be expected to be. This relates to Watson's findings discussed here, and raises a question for consideration: Are sibling caregivers more likely to provide input and experience on a non-contingent basis independent of the responses of young children? And if so, might rearing under such conditions tend to produce "depressed," listless, or disinterested youngsters who have little initiative with respect to school activities?

This question might be extended somewhat to ask about the longterm effects of the teaching style preferred by many Hawaiian mothers. Jordan (1976), for example, found that many Hawaiian mothers use very little verbal direction in interactions with their children in a problem-solving task. Instead they tend to adopt a co-participant role in which they apparently teach through largely non-verbal modeling rather than through a strongly verbal shaping process — the latter being the most commonly observed pattern among Mainland Caucasian mothers. While neither style is necessarily superior, Jordan did report that Hawaiian youngsters whose mothers used more verbal direction tended to perform better in school. In light of Watson's work, meanwhile, one might ask about the longterm effects on affective/motivational dimensions of a teaching style that operates in parallel rather than on a contingent or responsive basis.

Any discussion of stress in relationship to family life among Hawaiians should acknowledge the existence of child abuse. The problem has been discussed elsewhere in this report, with the fact being clearly established that Hawaiians are overrepresented in cases of confirmed abuse and/or neglect. High incidence of child abuse and neglect has implications with respect to stress among Hawaiian youth. In this regard Ritchie and Ritchie (1981) have offered an interesting analysis of the conditions Polynesian women face in New Zealand, conditions which may parallel those in Hawaii:

> For all these caveats, however, there is no denying that, according to the only existing authoritative study for New Zealand, of a total of 252 cases of abuse detected in a single year a staggering 172, or 63 percent, were Maori, Pacific Island, or mixed-race children. Thus, of every three cases detected, two came from an ethnic background that was to some extent Polynesian. In some way, and often within one generation, Polynesians have shifted from a profile of no child abuse to one of high child abuse. What has happened?
>
> . When Maori women become mothers in an isolated suburban setting the situation is generally more stressful for them than for their non-Polynesian neighbors. A number of years ago one of us (Ritchie 1964) reported very high stress scores for Maori mothers in a large New Zealand city. In 1958, when the data were collected, the rates of psychiatric disorder for this category of people were not conspicuously high. Ten years later we obtained identical data for a further sample and again we found evidence of high stress levels and commented that the

need to attend to this matter was urgent (Ritchie and Ritchie 1970). The stress, which was undifferentiated and very general, represented no recognizable patterning of scores into the usual categories, such as anxiety states, depression, mental breakdown, conversion hysteria, or other neurotic problems. So far as we know, neither in 1958 nor in 1968 was this information utilized in community or mental health services for the population concerned.

Since this stress does not fall into a recognized pattern, it is possible that the usual ways in which stress is reduced are not available to Polynesian migrant women, or perhaps to men (though we have no evidence concerning their stress levels). We postulate that there are patterns of handling stress within Western families which have not yet developed in Polynesian families. The Western woman converts the stress arising from the situation into which she has been forced into neurotic or psychosomatic symptoms, into strategies and tactics in her marriage, into visits to her doctor to procure more Librium or Valium, and increasingly into alcohol dependence (Bernard 1972). The Maori or Polynesian mother simply acts out. None of these strategies are satisfactory, but since we see little being done to provide women with other and better ways of removing stress or coping with it we think Maori and Polynesian women may slowly adopt the same tactics as European women. They may then display less child abuse (or learn to conceal it), but will they really be any better off? The matter, we repeat, urgently needs to be researched (p. 195).

Alan Howard (1974), in his book *Ain't No Big Thing*, explored the relationship of ethnicity to mental health and coping strategies. Using data from the Nanakuli studies (Aina Pumehana), Howard related several measures of "Hawaiianness" to measures of self-esteem, coping strategies, and other social variables. He employed both a Hawaiian Conceptual Test and a Middle-Class Conceptual Test. Overall, the implications of the study are that those individuals who score low on both measures of cultural knowledge tend to also score lower on measures of self-esteem and use less effective coping strategies. Other measures of Hawaiianness (percent Hawaiian ancestry, ethnicity as described by spouse, and cultural self-identity) show a negative relationship with self-esteem and social competence. These would be individuals who fit the description defined earlier of "marginal" people: people who are dissociated from both their original and the mainstream culture. Howard states: "We interpret these data as support for the proposition that knowledge of, and pride in, ethnic heritage is an important if not critical element for the development of social competence among contemporary Hawaiians." (pp. 225-226)

In terms of seeking help, the findings are ambiguous. In spite of testimony to the contrary (see p. 162), the available social indicator data show that Hawaiians are not using mental health facilities in disproportionate numbers (Department of Health, 1982). This is also backed up in a study of the use of Neighbor Island facilities (Mebane, Kamahele, & Carpenter, 1976). This may be partially attributable to the tendency to seek help in other ways. In *Nana I Ke Kumu II*, for example, Pukui, Haertig, and Lee (1972) report that many Hawaiians still seek help from *kahuna* practitioners or folk healers before they would go to a physician or hospital. *Ho'oponopono* (a type of Hawaiian family therapy) and prayer are still commonly used, sometimes in combination with modern medicine:

> The danger that lurks today when some Hawaiians pray and conduct *ho'oponopono* in sickness is that they turn spiritual enablement into 'faith healing.' While prayer can certainly facilitate recovery in many illnesses, prayer should go hand-in-hand with medical diagnosis and treatment. Too many Hawaiians today call in only the minister and forget the doctor. More than one client has said that, 'My *ho'ola* (healer, minister who practices healing) told me not to take the child to the doctor.' (pp. 141-142)

The concept of depression was not an unknown one to the ancient Hawaiians. There are a number of Hawaiian terms which mean or imply the dysphoric mood state and self-deprecatory behavior which is characteristic of depression in its clinical interpretation. (*kaumaha*: weight, heaviness, figuratively sad, depressed; *lu'ulu'u*: bent or bowed down as

with weight, sorrow, trouble). Pukui, Haertig, and Lee (1972) report:

> We know Hawaiians of the past recognized the depressed person. He was *loha*, drooping or wilting, 'as a branch hangs low, beaten down, as by rain.' (p. 246)

There may be in modern Hawaiians a form of depression which has no specific diagnostic referent. This may even be culturally unique to Hawaiians. It may be less functional to try to fit it into an existing diagnostic category than to simply recognize it as a separate but related phenomenon.

CONCLUSION

Modern Hawaiians seem to suffer from a new kind of depression, a being "beaten down," but not by rain, rather, by a sense of enormous personal loss. That this sense of personal loss could be caused by two centuries of rapid change away from Hawaiian culture and could, in turn, partially account for observed academic disparity has been called the "Culture Loss/Stress Hypothesis." This hypothesis has guided the review of theories and findings which can help explain the situation facing modern Hawaiians.

A recurrent theme has characterized recent descriptions of Hawaiian youth: the words "self-disparagement," "low self-esteem," "hopelessness," "alienation," and "demoralization" recur regularly. On the other hand, it was pointed out that the culture loss was not a complete one: that revival of Hawaiian culture has enabled more and more modern Hawaiians to re-establish links with their past.

The concept of stress as the underlying mechanism was shown to be a more universal explanatory construct, connecting body and mind with psycho-social forces. The situation confronted by Hawaiians was shown to be similar to that of other groups undergoing cultural stresses.

In attempting to define what stress is, the concept of depression was discussed. While some of the symptoms characteristic of clinical depression were similar to the traits observed in modern Hawaiians, others were not. There was not a complete match. A consideration of the cross-cultural meaning of diagnostic categories, however, pointed out that the clinical definition may be culturally limited and thus may not relate completely to the Hawaiian situation.

In support of this concept, data showing that Hawaiians are not over-represented in admissions to state mental health facilities was reviewed. It was emphasized that this finding could have multiple explanations, from a reluctance to seek psychiatric help to a lack of recognition of the situation as one requiring help.

What can be concluded? What does exist seems to be something similar to clinical depression, but not completely the same. It may be culturally unique to modern Hawaiians even though it was shown to have similarities to syndromes affecting other groups. It does seem to be embedded in a multi-level explanatory system suggested by the ecological model. It cannot be attributed solely to "historical" forces. Neither is it a purely individual phenomenon. The most severe limitation to our understanding may be semantic: we do not have a convenient label which completely fits the situation. It may thus be misleading to call it depression, but there is no other single term to describe it, except, perhaps, *loha*. It may, then, be more effective in terms of planning future research and interventions to center thinking around the concept of stress: of identifying the types of stressors which have affected and are affecting given individuals or groups and of identifying the kinds of physical and mental outcomes which these stressors produce. Specifically, **how can the particular stressors be identified which are most responsible for lowered academic performance, and what can be done about eliminating them or enhancing the capability to cope with them?**

It may be concluded, then, that the Culture Loss/Stress Hypothesis remains just that: a hypothesis which may be most useful in guiding future research and intervention for the benefit of modern Hawaiian students. There are several areas for further investigation:

1) What are the exact behaviors which make up the syndrome in modern Hawaiian young people? Lowered academic performance is there, low self-image, feelings of despondency and of being a stranger in one's own land. Less is known about some of the other symptoms which are related to clinical depression: thoughts of death or suicide, sleeplessness, changes in appetite or

weight, loss of pleasure in normal activities. These should be investigated further.

2) What is the epidemiology of the depressive syndrome? When does it begin? How severe is it for how many people? Why is there no disproportionate representation of Hawaiians in mental health treatment? How much of the real problem is even known about among mental health professionals?

3) Assuming that the existence of the problem is a real and immediate one for many modern Hawaiians, what kinds of intervention strategies might be most beneficial? If the use of mental health professionals is still not highly valued by the community, how can in-culture healers or others generalize their skills to helping more of their own community? Or should efforts be placed in education relating to stress reduction?

4) What of the many Hawaiians who do not suffer from this syndrome? There is evidence of increasing school success, of improving economic conditions, of Hawaiian leaders and potential leaders who are successfully making their way through the macro-system of modern-day America. How can their successes be converted to an image of success for the entire Hawaiian community?

Perhaps the most exciting prospect raised by consideration of the Culture Loss/Stress Hypothesis is that the future does not have to be depressing. Others have made encouraging breakthroughs in changing self-esteem through the creative use of modern media (e.g., Johnston and Ettema, 1982). This is what is seemingly needed: to turn around a community's point of view about itself. Many more young people today are able to say, "I am proud to be Hawaiian." In the future, people everywhere should be able to say, "If you want an example of a success story, look at the Hawaiians."