

E OLA MAU

THE NATIVE HAWAIIAN HEALTH NEEDS STUDY
HISTORICAL/CULTURAL TASK FORCE REPORT

The Native Hawaiian Health Research Consortium

ALU LIKE, INC.

Honolulu, Hawaii

December 1985

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PREFACE

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

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

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

In June 1985, DHHS provided funds to the Waianae Coast Comprehensive Health Center (WCCHC) to conduct the health

needs study. WCCHC was selected as the prime contractor because the Center had existing ties with DHHS and an established system to disburse the funds. WCCHC then subcontracted the study to ALU LIKE for the overall administration of the project.

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

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

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

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

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

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

I. Purpose of Report

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

II. Conclusions

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

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

C. Western impact, beginning in 1778, resulted in spiritual devastation and almost complete eradication of the Native

Hawaiians.

The main factors in this decimation were introduced infections, native hypersusceptability and lack of immunity, and haole (white) economic, political, social, cultural and military control, with resulting Native Hawaiian despair and, for many, loss of will to live in a world that had become hostile and no longer meaningful.

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

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

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

E. In spite of the grim health profile of our po'e, some traditional Hawaiian cultural strengths persist, and are even admired by some non-Hawaiians, e.g.,: reverence for nature, expressed as aloha 'aina (love of the land), communication with the

spiritual realm, group affiliation over individual assertion, sensitivity to others' moods, avoidance of confrontation, minimization of risk ("ain't no big ting"); child-rearing; desire to continue a basic lifestyle close to the land and sea within an extended 'ohana; and pride of heritage, such as in revitalization of mele (song), hula (dance), other arts and crafts, lawai'a (fishing), mahi'ai (farming), and lapa'au (Hawaiian medicine).

F. Two main options appear available:

1. Continue to ignore Native Hawaiian health problems as has been usual in the past.

Two subsets of po'e Hawai'i will emerge:

a. Native Hawaiians who will undergo further de-Hawaiianization and become assimilated as non-Native Hawaiians, even though they may occasionally be identified as Native Hawaiians.

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

b. Native Hawaiians who will continue as the landless, dispossessed, culturally-confused, sick, and thus, will persist as "the Native Hawaiian problem."

2. Kāko'o (support) Native Hawaiians in furthering our spiritual and cultural identity, so that through our improved coping skills,

self-esteem and support systems for political self-determination and economic self-sufficiency, we may regain our land base for pursuit of more meaningful lives and thus, improved well-being, including health.

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

1. Resistance to the dominant haole society, which may take two forms:

a. Passive resistance, while we quietly maintain aspects of our culture.

b. Active resistance, through confrontation and control, and thus, with loss of some of our traditional ways.

2. Biculturalism (Native Hawaiian and haole), which requires:

a. Tolerance, respect, understanding and kāko'o by non-Native Hawaiians.

b. By po'e Hawai'i:

(1) Reconstruction: adaptation by adoption of some non-Hawaiian modern technological advances, especially in urban centers.

(2) Revitalization: use of traditional cultural concepts and practices, where applicable, especially in rural areas.

III. Recommendations

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

Thus, the historical and cultural basis for our health plight must be the major consideration, and not merely concern for proximate causal factors, such as specified in the currently-fashionable government model of lifestyle, environment,

health care and biological factors; with programs only in terms of physical health promotion, disease-prevention and intervention.

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

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

2. Build upon current Native Hawaiian cultural strengths by incorporation of appropriate mea pono Hawai'i (valid Native Hawaiian values and practices), such as the basic concept of lōkāhi with the cosmos, self, others, land and sea, and 'aumākua in nurturing and maintaining mana; and 'olelo Hawai'i (Hawaiian language) as essential to restoring and maintaining our culture, and thus, our health.

3. Monitoring to assure that programs are of definite benefit to ka po'e Hawai'i, and not merely for promoting non-Native Hawaiian researchers and sustaining administrative bureaucracies.

C. Systematic and continuous collection, tabulation, and analysis of critical health data by Native Hawaiians on Native Hawaiians for health needs assessments and specific health programs for Native Hawaiians, with the setting of priorities based on importance of need, expertise available, receptiveness of ka po'e Hawai'i, and availability of funds and other resources.

The appropriate agency for these important tasks needs to be

carefully determined.

D. Definition of realistic, practical and meaningful goals.

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

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

1. Within the 'ohana and at the local Native Hawaiian community level.
2. Emphasize appropriate Native Hawaiian cultural concepts, language and practices.
3. Use modern communication methods, where appropriate, such as sophisticated television programs, produced by po'e Hawai'i, using Native Hawaiian cultural motifs and 'olelo Hawai'i (Hawaiian language).
4. Target specific groups with specific health problems, such as: pregnant teenagers, preschool youngsters with dental caries, youths with cigarette, alcohol and drug-abuse; patients with diabetes, high

blood pressure, obesity, and those at high risk for coronary heart disease and cancer.

5. Focus on: prudent nutrition, physical fitness, avoidance of harmful substances, stress-coping, self-care, understanding of common illnesses and complications, optimal use of health-care resources, avoidance of faddism, commercialism, and excessive dependence on professionals.

F. Education of health personnel.

1. Of culturally-experienced and sensitive Native Hawaiians.

2. At all levels beginning with hiapo (eldest sibling), mākua (parents, uncles, aunts), kūpuna (grandparents, elders), as teachers among peers and to juniors, within extended 'ohana and local Native Hawaiian community existing social support networks.

3. Education of Native Hawaiian health professionals, to include not only physicians and nurses, but health educators, health aides, health advocates, health coordinators, health planners, health researchers, and health administrators.

4. Support appropriate training of respected native healers.

5. Native Hawaiian cultural-awareness training of non-Native Hawaiian health professionals.

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

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

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

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

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

H. Integration of health programs with others concerned with:

1. Land: Regain and maintain Native Hawaiian land base through federal reparations for U.S. illegal overthrow of the kingdom and violation of Native Hawaiian indigenous people's rights. Return of federal ceded lands, pressure for state ceded lands and the Hawaiian Home lands, and proper protection of private Native Hawaiian lands, such as the Bishop Estate, Lili'uokalani Trust, Queen Emma lands, and threatened private Native Hawaiian family lands. Proper use of Native Hawaiian lands for Native Hawaiians: homes, access for

farming, fishing, hunting, wood and plant-gathering; Native Hawaiian community facilities, such as pā and marae (enclosed clearing), for Native Hawaiians' 'aha (gathering), hālāwai (meeting), hō'ike (show), celebrations, ceremonies; and for human services for Native Hawaiians.

2. Population control of further in-migration to prevent further unhealthful crowding and its other consequences, such as crime and destruction of natural resources.

3. Law: State civil rights law to assure representative health care for po'e Hawai'i.

Laws to restrict sale and use of harmful substances, such as tobacco, alcohol, and specified harmful processed foods.

Education of more Native Hawaiian culturally-sensitive attorneys, legal aides and mediators, with their placement in needed Native Hawaiian communities. Workshops on Native Hawaiian rights.

4. Political self-determination: Locally-elected Native Hawaiian councils and governing boards.

Representation of po'e Hawai'i on all government bodies.

Workshops on political organization and effective action on Native Hawaiian issues. Register every eligible Native Hawaiian to vote; provide transportation to voting booths.

5. Economic self-sufficiency: Job-training, especially for self-sufficiency in living from the land and the sea (vide infra - see below).

Native Hawaiian banks for loans at low interest to po'e Hawai'i.

Restraints on foreign multi-national control of Hawai'i economy and especially of Native Hawaiian lands.

6. Environmental protection against pollution and destruction of

our natural resources by government, developers, tourism, other commercial interests and the military.

7. Education: Hawaiian language and culture in all public and private schools, with instruction on Native Hawaiian rights and history of exploitation of Native Hawaiians, coordinated with health instruction at all levels.

Increased alternative education programs for Native Hawaiian school age youngsters incorporating health instruction within Native Hawaiian cultural context.

8. Housing: Preference for needs of local Native Hawaiians over desires of malihini (newcomer) and greed of developers.

Incorporation of appropriate Native Hawaiian design and architecture by Native Hawaiians in all construction for Native Hawaiians.

9. Transportation: Limitation on automobiles and roads to reduce auto-related morbidity and mortality, and restrictions on destructive air and sea transportation facilities and practices.

10. Energy: More use of natural energy sources; less dependence on foreign oil.

11. Historic sites: Protection, restoration, maintenance and proper cultural use of Hawaiian historic sites in regular celebrations, ceremonies, cultural 'aha (gathering), and historical dramas.

12. Communication: Appropriate representation (about 20%) of Native Hawaiian culture, language and personnel in all major media (TV, radio, newspapers).

Restriction of commercial advertising of health-harmful marketed products.

13. Lawai'a (fishing): Restoration of nā loko (fishponds) to be maintained by po'e Hawai'i; subsidized cooperative lawai'a until

such programs become self-sustaining. Appropriate nurturing and protection of Native Hawaiian marine food sources.

14. Mahi'ai (farming): Subsidized cooperative, diversified mahi'ai for local needs, engaging Native Hawaiians, until farming programs become self-sustaining; promotion of individual home gardens, and small-scale farming for family subsistence of Native Hawaiian food sources, such as, taro, 'uala (sweet potato), uhi (yam), 'ulu (bread-fruit), mai'a (banana). Models include Ka'ala and Makaha farms.

15. Language and culture: 'Aha Pūnana Leo (language nest) for preschool, child-care Native Hawaiian culture-language centers, conducted by trained Hawaiian language speakers and incorporating traditional Native Hawaiian cultural concepts, literature, and practices. Thus, a new generation of Native Hawaiian language speakers will replace the few remaining elderly ones.

THE REPORT

E OLA MAU: Native Hawaiian Health Needs Study

Historical and Cultural Task Force

OUTLINE OF THE REPORT

- I. Purpose of Report
- II. Methods
 - A. Membership of Task Force
 - B. Work and meetings of Task Force
 - C. Basic concepts and definitions
- III. Major Findings
 - A. Native Hawaiian movement and background of E Ola Mau Report
 - B. Medical history of ka po'e Hawai'i (Hawaiians)
 - 1. Kumulipo, the cosmos, and ka po'e Hawai'i Kahiko
 - a. Religion pervasive: lokahi with living, conscious, communicating cosmos
 - b. Ekolu piko, wailua, 'uhane, ola, ea, kino akua, 'aumakua, kinolau, mana
 - c. Favorable health practices
 - d. Native Hawaiians free of epidemic, contagious pestilences
 - e. Concepts of illness
 - f. Appropriate medical practices
 - 2. Fatal impact of 1778 and thereafter
 - a. Rapid depopulation
 - 1. Infectious epidemics
 - 2. Lack of immunity
 - 3. Cultural conflict

- b. Inadequacy of native medicine for new diseases
 - c. Ascent of Western medicine
 - 3. Monarchy overthrown with military aid of U.S.
 - a. Population shift
 - b. Major illnesses
 - c. Important health measures
 - 4. Health factors transforming Native Hawaiians
 - a. Outmarriage with cultural factors
 - b. Lifestyle, including cultural factors
 - c. Environment, including historical and cultural factors
 - d. Inadequate health care including cultural factors
 - e. Biological factors and related cultural factors
- B. Historical health profile and interacting causes and effects
 - 1. Collection and recording of health data
 - a. Varying definitions of Hawaiian, Part-Hawaiian, and Native Hawaiian
 - b. Varying population bases
 - c. Lack of systematic study of Native Hawaiian health needs
 - 2. Birth and death rates
 - a. In 1800s, low birth and high death rates
 - b. Later, reported higher birth rates and lower death rates of mixture of Native Hawaiians with non-Hawaiians, not of Native Hawaiians alone
 - 3. Infant mortality high for Hawaiians
 - 4. Life expectancy shortest for Native Hawaiians since

first records in 1910

5. Leading diagnosed causes of death rates highest for Native Hawaiians
 - a. Hawaiians leading in all major disease categories while Part-Hawaiians intermediate or similar to other races
 - b. Earlier years, 1900-1920s, tuberculosis, pneumonia, influenza and enteritis dominant; 1930 and thereafter, heart disease, cancer, stroke and accidents
 - c. Major causal factors in 20th century: heart diseases, cancer, stroke, accidents
6. Cancer
 - a. High cancer rates for both male and female Native Hawaiians first noted in 1970s
 - b. Shortened survival rates
 - c. Risk factors for cancer: smoking, alcohol, obesity, high-fat, salted, dried foods
7. Acute and chronic conditions
 - a. Native Hawaiians highest rate of acute conditions in Health Surveillance in 1977
 - b. High occurrence rate of lung disorders thought to be true for Native Hawaiians, but not systematically studied
 - c. "Arthritis" rate high for Hawaiians but types and specific rates not documented
 - d. Arterial hypertension mortality highest for Native Hawaiians first reported in 1962

- e. Coronary atherosclerotic heart disease highest for Native Hawaiians since 1962
- f. Rheumatic carditis highest in Native Hawaiian children first reported in 1951
- g. Kidney disease mortality highest for Native Hawaiian males since 1962
- h. Diabetes most prevalent in Native Hawaiians in first survey in 1963
- 8. Congenital-hereditary clubfoot highest for Native Hawaiians in first study in 1967
- 9. Teenage pregnancy rate highest for Native Hawaiians when first studied in 1976-1981
- 10. Dental caries highest among Native Hawaiian eighth-graders in 1973
- 11. Mental health
 - a. In first systematic ethnic study in 1979, Native Hawaiians had higher proportion than expected for some mental disorders in state mental health treatment facilities
 - b. Native Hawaiians had problems with communication in mental health facilities
 - c. Since first ethnic breakdown in 1978, in the state institution for mentally retarded, Native Hawaiians comprise the largest racial group
 - d. In 1981 school adjustment statistics, Native Hawaiians were high in special education enrollment
 - e. Alcoholism and other chemical dependancies:

Native Hawaiians ranked second to whites

12. Suicide

- a. Native Hawaiian males highest rate, especially in young
- b. Despair and cultural conflict may be increasing

13. Medical care

- a. Not systematically assessed for Native Hawaiians
- b. No longer free medical care for Native Hawaiians
- c. Native Hawaiians appear to be underrepresented in Medicare, HMSA plans, and overrepresented in Medicaid
- d. Reluctance to use Western medical and dental services
- e. Meager health care education
- f. Native Hawaiians are underserved by some Department of Health programs

14. Health professionals

- a. Physicians: less than 5% Native Hawaiians
- b. University of Hawai'i-Manoa, John A. Burns School of Medicine students: less than 8% Native Hawaiians
- c. Nurses; University of Hawai'i-Manoa, School of Nursing students: only 3% Native Hawaiians
- d. Public health; University of Hawai'i-Manoa, School of Public Health students: less than 2% Native Hawaiians
- e. University of Hawai'i-Manoa, School of Social Work: no data available on Native Hawaiian

students or faculty

f. Serious underrepresentation of Native Hawaiians in
all major health professions

C. Previous responses to Native Hawaiian health needs

1. Not examined systematically
2. Current report is only the third in modern times
3. Meager discussion of Native Hawaiian health needs in
media, academic communities, Native Hawaiian and
general communities
4. Only minor actions to date to address major problems

IV. Conclusions

- A. Health data not adequate on Native Hawaiians
- B. Native Hawaiian beliefs and practices effective for
promoting wellness, preventing, and controlling illness in
ancient times
- C. Western contact devastated and almost completely eradicated
Native Hawaiians
- D. Continued loss of culture, lands, status and power with
health as one factor in the decline
- E. Some traditional cultural strengths persist
- F. Two main options
 1. Continue ignoring health problems
 - a. Assimilation of a part of the population and
therefore problems of being "Native Hawaiian" will
be lost
 - b. Continuation of Native Hawaiians as sick, landless,
dispossessed, and culturally-confused will persist
as "the Native Hawaiian problem"

2. Support Native Hawaiians to regain health in addition to other aspects of culture
- G. Native Hawaiians may recover and maintain ethnic identity by:
 1. Resistance to western society
 - a. Passive
 - b. Active
 2. Biculturalism
 - a. Tolerance, respect, support and understanding by non-Native Hawaiians
 - b. Reconstruction and revitalization by Native Hawaiians

V. Recommendations

- A. Appropriate awareness of health plight
- B. Primary concern for Native Hawaiians
 1. Input from Native Hawaiians at all stages and control of programs
 2. Incorporate appropriate Native Hawaiian values and practices
 3. Benefit to Native Hawaiians, not just researchers and bureaucracies
- C. Systematic and continuous collection of data by appropriate Native Hawaiian agency
- D. Define realistic and meaningful goals
 1. Emphasize holistic health within Native Hawaiian cultural context
 2. Western standards not necessarily ideal or appropriate for Native Hawaiians

3. Avoid simplistic "solutions" to complex problems
- E. Health education of Native Hawaiian families
1. Within the family and at local Native Hawaiian community level
 2. Emphasize appropriate Native Hawaiian cultural concepts and practices
 3. Incorporate modern communication methods
 4. Target groups with specific health problems
 5. Focus on positive health and cultural aspects
- F. Education of health personnel
1. Culturally-experienced and sensitive Native Hawaiians
 2. At all levels - family and community, as well as professional
 3. Educate Native Hawaiian health professionals
 4. Support appropriate training of respected native healers
 5. Native Hawaiian cultural-awareness training of non-Native Hawaiian health professionals
- G. Coordinate with existing agencies
1. Appoint Native Hawaiian health administrators to coordinate, avoid duplication, fill gaps, monitor, evaluate
 2. Native Hawaiian community family health centers
 3. Investigate reinstitution of free medical care for Native Hawaiians
- H. Integrate health programs with those for:
1. Land: restoration of Native Hawaiian lands
 2. Population control of in-migration
 3. Law

4. Political self-determination
5. Economic self-sufficiency
6. Environmental protection
7. Education
8. Housing
9. Transportation
10. Energy
11. Historic sites
12. Communication
13. Fishing
14. Farming
15. Language and culture

HISTORICAL AND CULTURAL TASK FORCE REPORT
E OLA MAU (HAWAIIAN HEALTH NEEDS STUDY)

I. Purpose of Report

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

II. Methods

A. The Task Force was composed of 33 members from five of the main Hawaiian Islands; 28 members were Native Hawaiians. Occupations represented were 16 physicians, a nurse, a social worker, a nutritionist, a counselor and mediator, a health educator, a professor of biology, 2 professors of history, 2 professors of political science, 3 researcher-writers on Hawaiian culture, 4 community workers, an attorney, and a planner.

B. He mau halawai (meetings) were held every two weeks for five months, from June through October 1985, to review the mo'olelo (history) of the Hawaiian movement and the background for the E Ola Mau report; review the medical history of ka po'e Hawai'i (the Hawaiian people); study the changing health profiles of ka po'e Hawai'i with time in relation to historical and cultural events; kukakuka (discuss) above data and interacting causal factors and effects; formulate conclusions and recommendations; draft a report.

Two hālāwai were held in the Wai'anae and Waimānalo communities on O'ahu with local po'e Hawai'i for their reactions and input.

Responses and input from the November 1 1985 Conference at the East-West Center for health leaders throughout the state were also incorporated into the final report.

The following basic concepts and definitions were adopted for this

report:

1. Health or wellness is not freedom from abnormality, disease or death, because such a concept is not consistent with reality. Rather, health is the ability of a person or a people to live meaningful lives by adapting within a given, yet constantly changing, environment.

This holistic approach is consistent with the ancient Hawaiian concept, as given in detail later, of ola (health or life), lōkāhi (unity) with all aspects of oneself and all of nature.

2. A modern definition of illness is the perception of sickness by the patient; whereas, a disease is an entity defined by the modern western medical profession as having unique diagnostic criteria, implying certain causal and prognostic features, and warranting prescribed standard treatment.

3. A disease-causation model proposed by the U.S. Surgeon General in 1979 for the major causes of death, cited four contributing factors with their respective relative quantitative roles:

<u>Contributing factors</u>	<u>Relative role</u>
(a) <u>Lifestyle</u> . This refers to human behavior and implies individual choices with respect to nutrition, body hygiene, physical activity, rest, stress-coping, and self-abuse, such as with tobacco and alcohol.	50%
(b) <u>Environment</u> . This includes climate, natural resources, such as clean water; public sanitation, such as waste-disposal; population density; public behavior, such as crime and war; and disease agents, such as germs, chemicals, and ionizing radiation.	20%

These factors are controllable to some extent by collective group action.

- (c) Human biological factors. These are mainly 20%
genetic and intrinsic biochemical and cellular mechanisms which depend on biomedical research for identification and control.
- (d) Health care. This refers to availability, 10%
accessibility, acceptability, and efficacy of health facilities and health personnel.

Although the Surgeon General's report recognized interaction of the above-cited proximate causal factors, it gave major responsibility to individual lifestyle. Thus, the implication that health or illness was largely a matter of individual choice. However, the report did not consider how collective social factors, including historical and cultural features, such as racism, religious bigotry, depopulation, cultural degradation, economic exploitation, theft of land, and political oppression, may so dominate that the victims of these forces may have limited economic, educational and psychological resources to maintain health. Accordingly, the Historical and Cultural Task Force Report gives special recognition to multiple social factors, as well as to proximate biomedical factors in the causation of illhealth in Native Hawaiians. Similar recognition to social causation have been identified in other oppressed indigenous peoples, such as the Māori in New Zealand and the American Indians.

III. Major Findings

A. Native Hawaiian movement and background for E Ola Mau Report.

E Ola Mau (Native Hawaiian Health Needs Study) comes after 15 years of intense activism throughout Native Hawaiian communities statewide. Like the Native Hawaiians Study Commission Report (1983) this Health Needs Study is a response by the U.S. government to the Native Hawaiian movement (1970-present). This movement is a series of protests against land abuse, economic oppression, and the subjugation and prostitution of Native Hawaiian culture. Now, in 1985, the movement has evolved to a stage where Native Hawaiians are working for an economically self-sufficient land base and some form of political autonomy. We are also trying to reclaim Native Hawaiian cultural patterns, including Native Hawaiian religion and holistic health practices.

In its modern form, the groundswell of Native Hawaiian activism is both political and cultural. It has included resistance to evictions, to commercial development of sacred sites and farming areas, to suppression and commercialization of Native Hawaiian culture, and to military occupation of Native Hawaiian land. In the meantime, the new consciousness has also given rise to a revival of artistic interest in things Native Hawaiian: hula kahiko (ancient hula); 'Ōlelo Hawai'i (Hawaiian language), and various forms of arts and crafts, including canoe-building and lei-making.

Along with this artistic flowering has come a serious search for the spiritual source of Native Hawaiian culture. Because Native Hawaiians took their sustenance from the land, their daily activities--planting, fishing, building, even eating--expressed spiritual as well as physical aspects of being. This understanding of life as a relationship between the spirit of the land and the people of the land, between material survival and cultural

expression, between work and respect for the wondrous and varied bounty of nature--all this shaped Native Hawaiian philosophy, music, art, dance, language and, indeed, structured the core of Native Hawaiian kinship, the extended family or 'ohana. The gradual relearning of this cultural heritage has led Native Hawaiians to demand what our ancestors demanded at the time of U.S. annexation in 1898: a land base for the practice and transmission of our culture, especially taro cultivation and religious observances.

The movement's growth from community struggle and cultural resurgence to collective assertions of Native Hawaiian claims for religious freedom, political power and, finally, autonomy as a sovereign people, was preceded by a fundamental transformation in Hawai'i's economy. From dependence on cash crops of sugar and pineapple, and on military expenditures in the first half of the 20th century, Hawai'i's economy shifted to an increasing dependence on tourism and land speculation with rising investment by multi-national corporations in the second half of the century.

After statehood in 1959, burgeoning tourism led to an overnight boom in hotels, high-cost condominium and subdivision developments, and luxury resort complexes which necessitated ever-growing demands for land. Concentrated land ownership, a problem since the onslaught of plantation agriculture in the 1800s, had actually increased in the 20th century. Small landowners controlled less than 10% of the land. The military, the State and large private estates, foreign and American developers owned the remainder. As a result, large landlords drove up the price of land, capitalizing on the post statehood rush toward commercial development.

Already economically exploited and culturally suppressed, rural

Native Hawaiian communities, which had been relatively untouched during the plantation period, were besieged by rapid development of their agricultural areas beginning in the late 1960s. These areas--among them, Hāna, Maui; East Moloka'i; Keaukaha, Hawai'i; Nanakuli, O'ahu; Wai'anae, O'ahu; Waimānalo, O'ahu; Hau'ula, O'ahu--had managed to retain many traditional practices such as taro farming, fishing, and the spoken Hawaiian language. Given the effects of educational and religious colonization, and the decline of the native population, these Native Hawaiian communities, although remnants of a once dynamic civilization, were nevertheless crucial to the perpetuation of Native Hawaiian culture. They were also, predictably, the communities with the worst health profile in the islands. Their threatened extinction by urbanization and other forms of development was correctly perceived by many oppressed Native Hawaiians as a final attempt to rid Hawai'i of Native Hawaiians and their culture. In many ways, it was predictable that the Native Hawaiian movement would begin and flourish in rural areas where the call for a land base would be the loudest.

Struggles at Kuka'ilimoku Village in Kona; at Sand Island, Mokauea Island, Waimānalo, Kahana Valley, Wai'anae and Nānākuli on O'ahu; on the east end of Moloka'i; in Hāna, Maui; and the struggle to stop the bombing of Kaho'olawe island all illustrated concerns for a land base for cultural purposes. Emphasis was given to fishing, taro cultivation, Native Hawaiian religious worship and various aspects of Native Hawaiian culture, such as dance and language. Unlike other, non-Hawaiian struggles, these rural, Native Hawaiian struggles were specifically concerned with the practice of Native Hawaiian culture. Because neither the people nor their

culture can flourish without some kind of land base, Native Hawaiians organized their protests around a crucial common demand: land.

Claims to this land base were presented in several forms: as an argument for reparations from the U.S. for its involvement in the overthrow of the Hawaiian government in 1893 and the subsequent loss of Hawaiian nationhood and sovereignty; as a legal claim to special trust lands abused by the State and Federal governments (200,000 acres within the Hawaiian Homes Act and another 1.5 million acres of ceded lands in the Admissions Act) and by large estates, e.g., Bishop Estate and Lili'uokalani Trust; and finally, as a right of residence by virtue of indigenous status, sometimes called aboriginal rights.

Beginning in 1970, Native Hawaiian political organizations began to push their native claims at the same time that besieged communities organized against eviction and urban development. "The Hawaiians," a State-wide, grass-roots political organization, was formed in 1970 to redress abuses in the administration of Hawaiian Home lands. Meanwhile, Native Hawaiian and non-Hawaiian farmers in Kalama Valley tried to resist eviction that same year by the Bishop Estate and Kaiser-Aetna, who sought upper-income residential development on agricultural lands. "Kōkua Kalama," a militant Hawaiian organization, was formed to help the residents resist eviction. Later, as "Kōkua Hawai'i," this organization expanded to address the needs of Native Hawaiians State-wide.

The following year, the "Congress of the Hawaiian People" was created as a watchdog over the Bishop Estate, while another State-wide organization was formed in 1972 to lobby for reparations

from the U.S. government. Called ALOHA (Aboriginal Lands of Hawaiian Ancestry), this organization's efforts eventually led to the establishment (in 1980) of a Presidential Commission to study the needs and concerns of the Hawaiian people, including reparations.

By 1973, several organizations and struggles had appeared around the State. Tenants at Nawiliwili-Niumalu on Kaua'i struggled against their eviction and against resort development; kuleana land owners on Windard O'ahu organized as "Hui Mālama 'Āina o Ko'olau" (The Association to Protect the Lands of the Ko'olau) to stop development of their agricultural lands; the "Homerule Movement" formed as a political lobbying group for Hawaiians; and the "Waimānalo People's Organization" fought eviction by the State.

In 1974, the first nationalist organization of the movement, 'Ohana o Hawai'i (Family of Hawai'i) appeared with the case for the re-establishment of the Hawaiian Nation presented to various world forums, including the United Nations. A legal group was incorporated to press for reparations and other native claims (the "Hawaiian Coalition of Native Claims," now re-organized as the "Native Hawaiian Legal Corporation"). Meanwhile, grass-roots Native Hawaiians in Kona, Hawai'i, occupied a shoreline area, and constructed a traditional fishing village as a cultural action against planned resort development. On O'ahu, a major struggle erupted between farmers and land owners regarding urban sprawl into Waiahole and Waikane Valleys.

In 1975, the island of Moloka'i witnessed the birth of "Hui Ala Loa" (the Association of the Long Trails). As a political group representing a large Native Hawaiian constituency on Moloka'i, "Hui

Ala Loa" organized around native issues from beach and forest access, to water use and homestead land, to preservation of taro cultivation and fishing areas, to a moratorium on resort development. Meanwhile, on O'ahu, two community struggles took place: a successful fight by fishermen on Mokauea Island against their eviction by the State, and a less successful struggle against eviction by residents of He'eia Kea on the windward side of the island.

The "Protect Kaho'olawe 'Ohana" was formed in 1976 to stop U.S. military bombing on the island of Kaho'olawe. As a State-wide organization, the 'Ohana served to link various land struggles on each island. It also asserted a Native Hawaiian cultural alternative--Aloha 'Āina, love of the land--to Western practices of exploitation of both people and land.

In 1877, leprosy patients at Hale Mohalu began a long fight to prevent their relocation to Le'ahi Hospital. Their issue was abuse of both the patients (most of whom are Native Hawaiian) and the land, which had been entrusted to the State by the Federal government expressly for the care of the patients.

In 1978, Kaho'olawe 'Ohana members, Native Hawaiian homesteaders and other supporters, demonstrated at Hilo Airport against abuses of trust lands (part of the airport is built on Homestead land) and the bombing of Kaho'olawe. Meanwhile, the Hawai'i State Constitutional Convention passed a package of amendments concerning Native Hawaiians: a call for reforms in the Hawaiian Homes Commission; protection of traditional Native Hawaiian access rights to the land and sea for religious and cultural purposes and for economic subsistence; the promotion of the study of

Hawaiian language, history and culture; the abolition of adverse possession of more than five acres of land; and the establishment of an Office of Hawaiian Affairs administered by trustees elected by Native Hawaiians, and charged with the care of the land, resources, and revenues from the State and Federal governments specially earmarked for Native Hawaiians.

In 1980, Native Hawaiian residents of Sand Island, O'ahu, sought a live-in cultural park but were evicted and arrested by the State. In 1983, Native Hawaiian residents of Mākua Beach, O'ahu, asserted their aboriginal rights to live on the shoreline in a traditional way. They were evicted, and several arrests were made.

For thirteen years--from 1970 to 1983--Native Hawaiian discontent erupted in mass protests against land alienation and cultural destruction around the State. But where community struggle originally stressed the rights of "local" people, the political organizations began with a specific focus on the abuses of Native Hawaiian lands and Native Hawaiian people. With the birth of the Kaho'olawe 'Ohana in 1976, the discourse of protest expanded from a focus on land abuse to an argument for a positive alternative. Phrased in Hawaiian, this alternative of Aloha 'Āina signalled the merging of political protest with cultural assertion. Thus, Native Hawaiian communities did more than struggle against land development; they also argued for a preferred alternative to capitalism: Native Hawaiian land use ethics of preservation, conservation and respect for the sacredness of nature; and harmony between people, their culture and their environment. These ethics were taken directly from Hawaiian culture.

While the Native Hawaiian cultural revival focused attention on

Native Hawaiian dance, language and history, Native Hawaiians active in native claims struggles began to feel a sense of righteousness about their cause. This righteousness and pride were mixed with anger at the discovery that Native Hawaiians had been kept ignorant of their history by the colonizers. For example, many Native Hawaiians learned for the first time that they were fighting for a land base originally taken away by sugar planters and missionaries--two colonizing groups who had been praised in standard history books. They also discovered that the U.S., long described as the saviour of Hawai'i, had actively participated in the overthrow of the Hawaiian government, and in the extinguishment of the Hawaiian nation. Pride in things Hawaiian led to a critical look at things haole, and to a growing understanding that the "Americanization" of Hawai'i had meant the repression of Native Hawaiian people and the decline of their culture.

Through study, political action and cultural return, Native Hawaiians began to experience what indigenous people the world over had experienced in the de-colonization period after World War II: rejection of Western ways, and a re-education in the ways of their ancestors. For Native Hawaiians, as for other Third World people, this process of mental de-colonization led to cultural revival and political organizing. As Fanon and Cabral had predicted, the freeing of indigenous minds from the vise of the colonizers gave birth to a liberation struggle. American ideological hegemony in Hawai'i was threatened by the very presence of the movement.

If charted against Western values, the indigenous values that radical Native Hawaiians asserted, as well as the threat that they posed, are immediately clear.

Hawaiian Values: Aloha 'Āina

(Love of the people for the land)

Sacredness of nature

Interdependence of people and nature

Protection of nature

Conservation of nature

Respect for the inherent value of each living object

Use and sharing among people of all resources

'Ohana (extended family, the collective) as central

Laulima: cooperation among people; working together in harmony

Lōkahi: unity

Western Values: Capitalism and Individualism

(Primacy of the self; reproduction of profit)

Instrumental view of nature

Domination of humans over nature

Exploitation of nature

Endless consumption of natural resources

Commodification of people and nature for profit

Individual ownership and individual benefit

Individual as central

Competition among people--
Class against class;
individual against individual

Conflict, class antagonism

Native Hawaiians in rural communities who want to preserve taro patches, fish ponds, and other bountiful wild areas of nature to feed their families and to perpetuate their culture view urban and resort development, freeways, gas stations and the rest, as clear signs of a rapacious, exploitative value system that placed gain over welfare, waste and consumption over the needs of the common people.

In stark contrast to Western culture, Hawaiian values revealed a culture whose religion, politics and economics were grounded in a fundamental love for the land and its people. This culture presented an admirable--and to many Native Hawaiians--a preferred alternative, to the haole or Western way of life. More than this, such an alternative, if adopted by Native Hawaiian

communities, would ensure not only the preservation of the 'aina but also the perpetuation of Native Hawaiian people as Native Hawaiians, rather than as colonized Americans. In desiring to be what their ancestry had bequeathed to them, Native Hawaiians followed a path taken earlier by other people of color: rejection of the white mask and its values.

The return to their culture thus gave to Native Hawaiians a sense of cultural pride and creative identity denied them by colonization. In addition, the more Hawaiians came to understand their culture through its actual practice, the more they came to understand the need for land. Political direction grew from that need until, by the end of the seventies, there was a unified call for a land base.

This call was expressed in the 1983 Native Hawaiians Study Commission Report to the U.S. Congress, and is reiterated in this Historical/Cultural section of the E Ola Mau report. Simply put, Native Hawaiian health depends on Native Hawaiian integrity which, in turn, depends on Native Hawaiians controlling our own destiny. Such control must begin with the practice of living, indeed flourishing, in our own place--this 'āina we know as Hawai'i. Like animals and plants, Native Hawaiians need the land to flourish. Our first goal, then, must be the reclamation of Native Hawaiian land for Native Hawaiian people.

B. Medical history of po'e Hawai'i.

1. The medical history of ka po'e Hawai'i begins with Pacific Islanders who traced their origins to Kumulipo (the dark source) with the mating of Wakea, The Sky Father, with Papa, The Earth Mother, from which everything in the cosmos was derived. Simpler

forms were followed by more complex ones in an orderly sequence. Then appeared Hāloa, the first kanaka (man), from whom all po'e Hawai'i are descended. Great men became chiefs, and great chiefs became gods. Gods appeared as kinolau (many forms), not only in kanaka, but as plants, animals, rocks, ocean, rain, and wind. Indeed, the entire cosmos was living, conscious, and communicating as described below.

About 2,000 years ago, the islanders who later were to be called "Hawaiians," journeyed from the South Pacific in double-hulled canoes to settle in the northern apex of the triangle of the many Pacific Islands, later to be known as "Polynesia."

For more than 1500 years prior to the arrival of Captain James Cook in 1778, ka po'e Hawai'i were generally robust mid-Pacific island people adapting well over the centuries to their island ecosystems. From the first 100 or so settlers, the population burgeoned to an estimated 300,000 in 1778 (Table 1).

Table 1
Hawai'i Population Estimates by Major Ethnic Stock in
1778, 1893 and 1983*

Ethnic Stock	1778		1893		1983	
Hawaiian	300,000	100%	40,000	45%	179,300	18%
Pure	300,000	100	34,000	38	9,300	1
Part			6,000	7	170,000	17
White					300,000	31
U.S.-Europe			12,000	13		
Portuguese			8,000	9		
Asian			30,000	33	392,000	40
Other					108,700	11
Total	300,000	100%	90,000	100%	980,300	100%

*Approximate figures from Schmitt; Department of Health.

For the latter 500 years, they had remained in isolation from the rest of the planet, after two main 2,000-mile, open-sea, canoe migrations from the South Pacific.

a. Ho'omana (religion) dominated all aspects of life and stemmed from 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 self--na'au (mind), kino (body), 'uhane (spirit), wailua (dream soul) and others--'ohana (family), nature, 'aumākua (ancestral gods), kāhuna (priest-specialists), and ali'i (deified chiefs), yet individual self-reliance; recurring life-cycle of re-birth, growth, maturation, mating, parenting, death, eternal ea (spiritual life force) and ola (physical life) in kinolau (many forms).

b. Some Hawaiian concepts of self, anatomy and physiology.

He kanaka (a person) was part of a continuum with his ancestors before him, all of his 'ohana (family) and nature about him during his physical existence on earth, and with his offspring and succeeding generations after him. An individual alone without these relationships was "unthinkable."

These relationships were promoted by informal favorable thoughts and spiritual communication, as well as formal rituals, to maintain soundness of kino (body), beauty and grace, personal skills, and social, economic and psychic security.

A person's anatomy reflected these concepts. For example,

there were three body piko (centers):

Ka piko po'o (head center), represented by the open fontanel of the infant's skull, was the site of intercommunication between the person's 'uhane (spirit) housed within his skull, and with his departed kūpuna (ancestors). Since the beginning (Kumulipo, dark source), these ancestors had become 'aumākua (deified family guardians). The personal 'uhane was also associated with ka mauli (the life principle) and with ea (the breath of life) that was universal.

Ka piko waena (navel) represented the person's link with his mākua (parents) beginning with fetal, intrauterine existence. This piko covered his 'ōpū (abdomen), which housed his na'au (gut). The na'au was the seat of the person's mana'o, learning and knowledge. Thus, na'auao (enlightened gut) was wisdom, and na'aupo (dark gut) was ignorance.

Ka piko ma'i (genitals) was especially sacred because it was the means for the person's procreative powers and thus, represented succeeding generations forever.

Just as everything in the cosmos was living, conscious and communicating, each part of the human physical kino (body) was similarly endowed with special aka or 'uhane (spirit) or akua i ke kino (god or spirit in the body), capable of thinking, sensing, relating, and acting on its own.

Mana'o was the person's thinking, rational conscious self when the individual was awake. It was housed in the na'au (gut). It died when the body died.

Kino wailua was the second soul which assumed control when the person was asleep. It often wandered away from the physical body

but always returned.

Kino akua were body spirit or god forms who were responsible for the person's body functions, motivations, and actions at subconscious levels. At times, some of these forms would wander from the person's physical self.

Ka luna a na akua a apau was the overall coordinator or controller of other kino akua in the person's physical body. It had extensive knowledge, including knowledge of the future. This was most effective when the person's mana'o made special effort to communicate with this spiritual entity. Such efforts took the form of meditation, ho'omana (prayer), daydreaming, and formal rituals such as the 'awa ceremony.

Manawa referred to the person's emotions and feelings, which were non-discursive. Like dreams and mana'o, manawa were affected by ka luna a akua a apau.

'Ike (attention or knowledge) had two forms: the first was ordinary thinking, willing, imagining, and remembering of the mana'o. The second was 'ike papalua, which included telepathy, precognition and clairvoyance. In the second form, the mana'o was passive, relaxed and receptive. Mana'o also became relaxed thru 'awa (drinking) or when one was in a trance, via a medium or meditation. In this passive, relaxed state, the mana'o was readily influenced by internal or external spiritual forces.

Varieties of aka, 'uhane or akua outside of the person might enter and noho (possess) the person and account for his behavior.

Any disturbance of the foregoing complex relationships could lead to loss of mana and thus illness (see below).

c. The foregoing concepts were the basis for generally favorable

health practices: high-fibre, high-starch, low-fat, low-sugar, ample protein, 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 'ahupua'a (sea-to-mountain region); cooperative subsistence economy without private land ownership; unknowing control of potentially harmful microorganisms; and holistic medical care as described below.

d. Because of their long geographic isolation of more than 500 years, the Hawaiians of old were free of epidemic, contagious pestilences. However, they did have some focal infections, including a low frequency of dental caries, as observed in skeletal remains. Metabolic disorders, such as gouty, degenerative and rheumatoid arthritis occurred, were also evident in pre-contact human bones, so other similar soft-tissue maladies may have existed among those at high risk. One case of metastatic cancer has been identified in pre-contact skeletal remains. Trauma was probably the most common class of ailments. Poisoning was rare. "Kava debauchery" among some ali'i was the only, and mild, form of drug "addiction." The few documented instances of mental illness contrast with Captain Cook's description of the natives as "social, friendly, hospitable, humane...blessed with frank and cheerful disposition." Some congenital-hereditary defects were known, the best documented being clubfoot, which is related to inbreeding (vide infra).

e. Concepts of illness:

Wellness represented adequate personal mana, which resulted from harmony with the various aspects of the collective self, 'ohana, others, nature, 'aumākua and other akua (gods) compliance with nā

kapu, and frequent communication with the spiritual realm, which also provided protection against external noxious influences.

Illness represented loss of mana, which resulted from disharmony with self, others, nature, the many akua, violation of a kapu, or failure to communicate properly with the spiritual realm. Any of these inadequacies might account for failure of protection against harmful effects of external factors, such as 'anai (curse) or 'anā'anā (sorcery). Thus, maintaining proper relationships was the best prevention against loss of mana and ill health.

Once illness had occurred, diagnosis was a matter of determining the mechanism of loss of mana. Treatment was directed at restoring the lost mana. As a start, the patient himself, especially if he were a commoner, assessed and managed his illness, having been trained since early childhood in self-reliance.

If he did not recover, he would likely seek the care of an experienced kupuna 'ohana (elder member of the family). Only if this failed, and he could pay the appropriate professional fees, such as a hog, would he seek the care of a kahuna lapa'au (physician) at the heiau ho'ola (healing temple).

f. Medical practices, appropriate for the setting and time, included:

- (1) Integrated psycho-spiritual methods: prayer, revelation, suggestion, extra-sensory perception; faith-healing, sorcery; and group-therapy.
- (2) Physical methods: careful observation; palpation, body-molding, massage, manipulation; clyster-enema, hydro-thermo-heliotherapy; and fracture-setting.
- (3) Pharmaceuticals as part of rituals with symbolism; empirical

effective use of mild narcotic 'awa, cathartics kukui and koali, anti-diarrheal pia; pōpolo, koali, noni for poultice; and mineral alae.

(4) Surgery: incision of abscess; prepuce subincision; minor resection; amputation; and trephining.

(5) Experimentation: systematic observation of all phenomena with detailed nomenclature and classification; empirical clinical trials with medicinals; and autopsy and animal research.

(6) Education: 'ohana training of each child in self-care; experienced kupuna (family elder); kahuna lapa'au (health specialist) training at heiau ho'ola (healing temple) with careful selection of haumāna (students) and a rigorous, 15-20 year curriculum.

2. The fatal impact of foreign contact may be considered in a first period from the arrival of Captain Cook in 1778 to the illegal haole overthrow of the monarchy in 1893:

a. Rapid depopulation from about 300,000 to about 40,000 (decline of 87%) (Table 1), termed both "holocaust" and "genocide," resulted from three main factors:

(1) Infectious epidemics in the following sequence: Gonorrhea, syphilis, tuberculosis, hepatitis (?), ma'i oku'u [cholera (?), typhoid (?)], measles, infectious coughs, mumps, infectious diarrheas, influenza, recurring measles and infectious coughs, four major smallpox epidemics, leprosy, scarlatina, and diphtheria.

(2) Lack of immunity, hypersusceptibility, genetic and metabolic factors.

(3) Cultural conflict, haole domination, and Hawaiian despair.

The introduction of haole firearms, ships, metals, and machines.

Concepts of economic exploitation, private property, and money economy.

The 1819 overthrow of nā kapu by the ruling ali'i; moral disintegration; and insanitation.

The 1820 arrival of missionaries: Christianization, Calvinist work ethic. Western concepts of time, the clock and the calendar: reading, writing; perceived superiority of western civilization over the native's "primitive, savage" state; thus, the condemnation of native beliefs and practices.

Decline of ali'i (chiefs) leadership with central monarchy controlled by haole oligarchy.

Commercial exploitation of maka'āinana (commoners) by some chiefs and haole with whaling, sandalwood, and later, sugar and pineapple industries.

Foreign military threats by Russia, France, Britain, and the United States.

The 1819-1859 imposition of a western judicial system.

The 1848-50 Mahele and Western legalized theft of Native Hawaiian lands with loss of land-use and access rights by Native Hawaiians; disruption of 'ohana and ecosystems; separation of natives from 'ahupua'a.

Replacement of subsistence economy by market economy with profit and materialism, controlled and promoted by the haole oligarchy; malnutrition; haole pressure for capitalist agriculture.

Dismantling of 'ohana and kahuna educational system; replacement by de-Hawaiianizing western educational system which did not train natives for leadership, but for subservience to haole rule.

New social ills: alcoholism, tobaccoism, prostitution, vagrancy,

and crime; racism; malcoping with stress; spiritual devastation.

Native Hawaiians' resistance to plantation labor schedule and wages, preferring traditional mahi'ai (farming) and lawai'a (fishing) system to meet local 'ohana needs.

The 1852 importation of foreign laborers, and the growth of "plantation mentality."

b. Inadequacy of traditional native Native Hawaiian medicine in combating new haole illnesses, even with foreign adaptations. Outlawed kahuna lapa'au went underground. New "kahunaism" (sorcery) was sensationalized.

c. Ascent of haole medicine was initially in the introduction of polypharmaceuticals, and purging with blood-letting--often more harmful than beneficial.

Haole surgery, however, was perceived as superior, with metal instruments, and the techniques of ligature to arrest bleeding and suturing to close wounds. Western public health measures replaced the old kapu system. Initially, they too, were ineffective, beginning with the first quarantine of all harbors in 1836.

In 1850, a Board of Health was created with seven members--all haole.

In 1854, smallpox vaccination was made compulsory, but 3 smallpox epidemics followed.

In 1859, the Queen's Hospital was founded by Kamehameha IV and Queen Emma with a haole director and free haole medical care for Native Hawaiians.

In 1865, the Leprosy Segregation Act established a receiving hospital in Kalihi, and confirmed leprosy patients were exiled to

Kalawao, Moloka'i, where there was no formal, organized medical care.

In 1884, a government hospital was built in Wailuku, Maui; later, others in Koloa (Kaua'i), and Hilo (Hawai'i), were staffed by haole physicians.

In 1885, the Lunalilo Home for elderly and infirm po'e Hawai'i was built in Makiki, Honolulu, by sale of extensive lands of the estate of the late king. In the same year, Kapi'olani Home for non-leprous kamali'i (children) of leprous mākua (parents), was established by Queen Kapi'olani in Kaka'ako.

In 1890, Kapi'olani Maternity Home was opened in Makiki by the Ho'oulu a Ho'ola Lāhui Society founded by King Kalākaua and Queen Kapi'olani "to save the Hawaiian race."

3. Overthrow of the monarchy (1893) to the present is a convenient second period for separate consideration. The illegal dethronement of Queen Lili'uokalani by haole insurrectionists with the aid of the U.S. minister and U.S. armed forces was called "an act of war" by United States President Grover Cleveland who added, "the rights of the injured people...we should endeavor to repair." The haole Provisional Government and succeeding anti-democratic Republic of Hawai'i denied voting rights to the indigenous Native Hawaiian people and other non-whites. Annexation of Hawai'i to the U.S. in 1898 was by Congressional Resolution without consent of, or compensation to, ka po'e Hawai'i and with the taking of almost 2 million acres of their lands. Cleveland said at the time of the annexation: "a miserable business...I am ashamed of the whole affair."

a. Population of ka po'e Hawai'i changed dramatically as shown in

Table 1: Pure Hawaiians declined from about 34,000 to about 9,000; Part-Hawaiians increased from about 6,000 to about 170,000. However, by 1980, all Native Hawaiians comprised only 18% of the total island population.

b. In the earlier years, the major illnesses were: an 1895 cholera epidemic, an 1897 typhoid outbreak, and in 1899, bubonic plague. In 1901, tuberculosis was the leading cause of death followed by influenza-pneumonia, with the highest rates for ka po'e Hawai'i. From 1910 to 1950, syphilis mortality was highest for ka po'e Hawai'i.

c. Important health measures during this period included:

In 1896, the Bureau of Vital Statistics was established by the Board of Health.

In 1899, the first sewers were installed. The first food commissioner, a haole, was appointed.

In 1906, the first public health nurse, a haole, was assigned at Palama Settlement.

In 1909, a U.S. Leprosy Investigation Station at Kalawao was established by Act of Congress. By 1911, the Station had closed because Native Hawaiian leprosy patients refused to submit to the insensitive, dehumanizing care provided at the facility.

In 1913, a sanitary engineer, a haole, certified the potable water sources.

In 1914, the Hawaiian Protective Association was established. It reported deplorable health conditions among urban Native Hawaiians.

In 1916, the first school of nursing at Queen's Hospital began with a haole director.

In 1921, Waimano Home was established for the mentally

retarded; po'e Hawai'i comprised the largest ethnic group.

In 1922, homesteading on Hawaiian Home Lands was created by act of Congress, but under the territorial government, for "rehabilitation" of ka po'e Hawai'i. The program failed because third-class raw lands were assigned without suitable infrastructure, house-financing was meager, and most of the lands were commercially leased to non-Native Hawaiians for funds to support the bureaucracy, because no government funds were provided for administration of the program.

In 1930, a new mental hospital was built at Kane'ohe with a haole director.

In 1965, Medicare was started; po'e Hawai'i were underrepresented.

In 1966, Medicaid was started; po'e Hawai'i were overrepresented.

In 1967, the University of Hawai'i-Mānoa, John A. Burns School of Medicine opened with its first class of 25 haumāna (students); none was kanaka Hawai'i (Hawaiian person). Only one member of the faculty was kanaka Hawai'i.

In 1976, Alu Like was founded as the state level federal Native American agency for Native Hawaiians.

In 1977, ALU LIKE completed a health needs assessment, but without funds for health programs.

In 1980, the Office of Hawaiian Affairs was established by the state constitution, but its only health program has been a small rehabilitation service for male alcoholics.

4. Health factors transforming ka po'e Hawai'i during this period were similar to those for other exploited indigenous peoples, such as the American Indians and the Māori:

a. Outmarriage was reflected in the declining number of pure Native Hawaiians to less than 9,000 in 1983, and the rise in Part-Hawaiians to about 170,000 in 1983.

b. Lifestyle.

Nutrition "fixed" by profit-oriented, multi-national-controlled, commercially-processed food importations promoted by marketing propaganda. Few Native Hawaiians have the accessibility and opportunity to live off the land and sea as in earlier times.

Self-abuse by cigarette-smoking and alcohol promoted by commercial interests, and illicit harmful substances by the underworld.

Malcoping with stress, lack of physical fitness, reckless recreation.

Faddism and commercialism in the dominant haole health care system which is discomfoting to many Native Hawaiians.

c. Environment.

Pollution and destruction of natural resources by urbanization, tourism, and the military. Overpopulation by non-Hawaiians, increasing automobile-addiction, crime; homelessness of Native Hawaiians.

Racism, miseducation ("cultural imperialism"), and poverty. The Massie case of 1922 fanned anti-Native Hawaiian racism.

Continuing loss of lands, culture, language, status, power, self-determination, self-sufficiency, and social support systems of ka po'e Hawai'i. Unemployment; employment of Native Hawaiians in lower-paying, foreign-controlled industries; emigration for better opportunities elsewhere.

Exploitation; lack of wholesome Native Hawaiian role models.

d. Inadequate health care as evidenced by the following:

Lack of availability and accessability to health services. Lack of acceptability by Native Hawaiians. Lack of health facilities, lack of Native Hawaiian health professionals. Insensitivity of dominant culture, non-Hawaiians, and some Native Hawaiians to Native Hawaiians. Lack of adequate and culturally appropriate health education.

e. Biological factors. Absence of study of heredity and acquired disordered cell mechanisms as possible unique responsible factors in Native Hawaiians.

f. In spite of adverse health profile, there are some favorable strengths. Since 1970, there has been both cultural reconstruction and revitalization. (see Methods II.A, and Conclusions IV.E.)

C. Historical health profile and interacting proximate causes and effects.

1. Irregular, non-standardized collection and recording of health data.

a. Varying definitions of Hawaiian, Part-Hawaiian, and Native Hawaiian.

State vital statistics: Based on self-reported parentage.

Household surveillance: Based on self-reported parentage.

U.S. census: Based on self-reported single choice only, with "Native Hawaiian" not specified as a choice.

b. Varying population bases.

c. Lack of systematic study of Native Hawaiian health needs.

2. Birth and death rates.

a. In the 1800s, birth rates were low, 21.3 to 41/1000/year, while death rates were high, 26.4 to 45.8. These figures reflected the

more than 80% decline in the indigenous population during that century from introduced infections, and the natives' social, cultural, political and economic disintegration, with resulting malnutrition, insanitation, and despair.

b. In the 1900s, after annexation, the initially somewhat higher birth rates and declining death rates were derived from a rapidly increasing mixed non-Hawaiian and lesser Part-Hawaiian, population undergoing western industrialization.

3. Infant mortality.

Higher infant mortality rates for Native Hawaiians continued from the early 1900s into the 1980s, in spite of the rising Part-Hawaiian population. No special attention was given to this Native Hawaiian health problem. In 1983, Native Hawaiians had higher rates of suboptimal prenatal care, illegitimate births, and congenital anomalies. Postulated multiple causal factors include genetic and other intrauterine defects, immaturity, malnutrition, inadequate maternal personal hygiene, lack of medical care, inadequate housing, trauma, poverty and stress.

4. Life expectancy.

In 1970, the shortest life expectancy of 67.6 years for Native Hawaiians vs. 74.2 for the total state population continued a trend since the first calculations in 1910. No special attention was given to this Native Hawaiian health problem.

5. Leading diagnosed causes of death.

a. From 1910 to 1980, in every major disease category, Hawaiians had the highest mortality rates. Rates for Part-Hawaiians were intermediate or similar to those for all races.

b. In the years 1910-1920, tuberculosis, pneumonia, influenza, and

enteritis were dominant. Beginning in the 1930s, heart diseases became prominent. Since 1950, the leaders have been heart disease, cancer, stroke and accidents. Mortality rates have generally declined, except for cancer, stroke and accidents.

c. The main causal factors for high mortality of Native Hawaiians in the early 20th century were probably hypersusceptibility, poor personal hygiene, malnutrition, lack of medical care, inadequate housing and crowding, and insanitation. No special attention was given to this Native Hawaiian health problem. Causal and risk factors for the current major illnesses are considered in other sections.

6. Cancer.

a. In the first report on ethnic differences in cancer incidence in 1954, Native Hawaiians ranked third for stomach and breast cancer, fourth for lung cancer and second for liver cancer, the only anatomic sites examined at that time.

b. However, by 1973 to 1977, Native Hawaiian males had the highest incidence rates for cancer of the esophagus, stomach, pancreas, lung and reticuloendothelial system.

Native Hawaiian females had the highest rates of cancer of the esophagus, stomach, lung, larynx, breast, uterine cervix, ovary, kidney, urinary bladder, thyroid, liver-biliary tract, and pancreas.

Native Hawaiian males had the greatest percentage 5-year increase in incidence of cancer of the stomach and lung. Native Hawaiian females had the greatest percentage increase in the incidence of cancer of the lung, and the lowest percentage decrease in the incidence of cancer of the cervix.

c. From 1960 to 1969 Native Hawaiians also had the shortest

survival rates for cancer of the breast, colon, and rectum.

d. Risk factors such as, cigarette-smoking, alcohol, obesity, high-fat, and dried salted fish foods, prevalent among Native Hawaiians, do not adequately explain the higher incidence of cancer in Native Hawaiians. No special attention was given to this Native Hawaiian health problem until the 1985 State Legislature appropriated \$100,000 for Hawaiian cancer research.

7. Acute and chronic conditions.

a. In 1980 household surveillance data, Native Hawaiians self-reported the highest rate of all acute conditions, and the highest for respiratory and digestive conditions. In 1977, Hawaiians reported higher prevalences, compared to all races, for: high blood pressure, diabetes, arthritis, heart trouble, and stroke; while Part-Hawaiians reported higher rates for asthma and chronic bronchitis. No special attention was given to this Native Hawaiian health problem.

b. Asthma and chronic bronchitis are among lung disorders thought to have high occurrence rates in Native Hawaiians. Emphysema commonly coexists with chronic bronchitis, and both conditions are aggravated by cigarette-smoking. Hypersusceptibility of Native Hawaiians to tuberculosis, lung cancer and chronic obstructive lung disease have suggested a genetic predisposition of Native Hawaiians, such as has been observed in other Polynesians. However, to date, there has been no systematic study of these maladies in po'e Hawai'i.

c. Degenerative, rheumatoid and gouty arthritis, which have been observed in skeletal remains of pre-Cook Hawaiians, but no systematic investigation has been conducted of these joint diseases

in contemporary po'e Hawai'i.

d. Arterial hypertension mortality was first clearly demonstrated in 1962 to be greatest in Native Hawaiians during the 8-year period of 1949-1956. In 1966, when high blood pressure was studied among 1,167 government and telephone company male employees, the highest prevalence rates were in Hawaiians and Part-Hawaiians. This was especially evident in those who were overweight. Other factors predisposing to high blood pressure appeared to be excessive sodium (salt) ingestion, physical inactivity, and stress malcoping. No special attention was given to this Native Hawaiian health problem until 1985, when the Moloka'i Heart Study on 200 Moloka'i Native Hawaiians began.

e. Coronary atherosclerotic heart disease mortality was also first reported in 1962 to be highest in Native Hawaiians grouped with other Polynesians, as compared to non-Polynesians. In 1967, hospital incidences of coronary heart disease (as cases of acute myocardial infarction), were 319/100,000/year for Hawaiian men, 200 for Part-Hawaiian men, and only 141 for Japanese men. Among these cases, hospital deaths were more frequent among Hawaiian men, 42%; Part-Hawaiians, 23.6%; and Japanese, 17.2%. In 1969, coronary risk factors were compared in 42 Native Hawaiian vs. 68 Japanese men who had had myocardial infarction. Native Hawaiians had higher body overweight indices, higher blood pressure, larger hearts, and greater frequency of diabetes than Japanese men. Serum cholesterol values were high in both races. Part-Hawaiians, but not Japanese, had greater than control coincident diabetes and family history of cardiovascular disease. Part-Hawaiians exhibited more sporadic excessive eating and beer drinking, greater day-to-day calorie

intake, ate more total fat and saturated fat, and less fibre, engaged in more physical activity, and admitted more frequent mental stress than their Japanese counterparts. No specific attention was given to this problem prior to the 1985 Moloka'i Heart Study.

f. Rheumatic carditis was first reported in 1951 to be most prevalent in kamali'i Hawai'i (Native Hawaiian children). In the latest report in May 1985, kamali'i Hawai'i had a rate 18 times that for ka po'e haole, second only to that of Samoans. No special attention has been given to this Native Hawaiian health problem.

g. Kidney disease mortality was first reported in 1962 to be highest in Native Hawaiian males and high (but not highest) for Hawaiian females, ages 35-74 years. In 1979, Native Hawaiians were reported as the most prevalent (29.5%) ethnic group among end-stage kidney disease (renal failure) patients. Leading types of kidney disease include: chronic nephritis, diabetes-associated, pyelonephritis, hypertension-associated, and lupus. Heredity, excessive dietary protein, fat and sodium, infection, immune disturbances, and toxic chemicals are among causal factors. No special attention has been given to this Native Hawaiian health problem.

h. Diabetes mellitus was first reported to have highest prevalence among Native Hawaiians in 1963. In that year, of 38,103 employed adults on O'ahu, Hawaiians had a blood glucose-diagnosed diabetic rate of 48.8/1,000, vs. 18.4 for all races. Part-Hawaiians were intermediate with a rate of 26.6/1,000. In 1966, a study on the island of Ni'ihau disclosed 8 diabetics among 60 Native Hawaiian men, a prevalence of 120/1,000. Most cases of diabetes appear to be

inherited, although the disease is not a single gene disorder. Expression is enhanced by obesity, high fat intake and infection. Diabetes also accelerates atherosclerosis, is often associated with high blood pressure, and is a common cause of chronic kidney disease. No special attention has been given to this Native Hawaiian health problem.

8. Congenital-hereditary studies in 1967 revealed a high frequency of clubfoot in Native Hawaiians. The earliest evidence of this deformity in po'e Hawai'i is in the pre-contact skeletal remains recovered from Mokapu, O'ahu. In 1969, in 913 reported cases of clubfoot, the incidence for Hawaiians was 68.12 per 10,000 births, 11.21 for haole, and 5.67 for Asians. There was no evidence for associated environmental factors. These data support a genetic hypothesis for clubfoot.

9. Teenage pregnancy rates for girls, less than 18 years, were highest (78.2/1,000) for Native Hawaiians vs. 37 for haole from 1976-1981. Native Hawaiians had a higher proportion of live births and a lower proportion of abortions. However, "no prenatal care" was twice as high for Native Hawaiians, and 87% of Native Hawaiian teen births were "illegitimate" compared to 76% statewide. These statistics may reflect persistence of some traditional precontact Hawaiian values toward mating, childbirth and the infant, as previously described.

10. Dental caries.

In 1973, the prevalence of decayed, missing or filled (DMF) teeth was highest (9.38) among Native Hawaiian 8th-grade public school youngsters compared to other racial groups. This rate correlated with the high frequency of ingesting starchy foods and

sweets. In 1984, the Health Concerns Committee of the Association of Hawaiian Civic Clubs submitted a proposal for a preschool dental health program for Hawaiians. This proposal still awaits funding.

11. Mental health.

a. In 1979 in state mental health facilities, Native Hawaiians had more transitional situational disorders, behavioral disorders and other personality disorders, mental retardation, and drug abuse than expected from their proportion in the mental treatment population. Native Hawaiians ranked highest for mental retardation, drug abuse, "missing data," and "diagnosis deferred."

b. These data suggest that while Native Hawaiians may be seen in mental health facilities, they may not communicate fully. Possible reasons are given in an Alu Like 1983 report: Native Hawaiians have unique problems because they are an indigenous people living under a non-indigenous government. Cultural conflicts between the traditional personal, family, social behavior of old Hawai'i vs. modern haole socio-economic competitive pressures generate mental stress and emotional disorders. No specific attention has been given to these Native Hawaiian mental health problems except for a program for Hawaiians with alcoholism funded by the Office of Hawaiian Affairs (see below).

c. During the 5-year period, 1978-1983, at the state institution for the mentally retarded, Waimano Training School and Hospital, Native Hawaiians were the largest racial group and comprised 32% of the 1,109 admissions.

Proximate medical causal factors include: congenital-hereditary defects, birth injuries, brain infections, trauma, malnutrition, alcoholism, other toxicity, and post-natal deprivation.

d. School adjustment.

In 1980-81, Native Hawaiian children were overenrolled (31.8%) in special education, comprised 36.4% of those with specific learning disabilities, 30% of educable mentally-retarded, 31% with impaired preschool learning, 33.1% of the deaf, and 30% of the deaf and blind.

Native Hawaiian school children scored lower in standardized tests than the national norms, and had a higher proportion of excessive absences than non-Hawaiians.

A 1983 Native Hawaiian Educational Assessment Project report has made some recommendations, but without coordination or integration with a holistic approach to Native Hawaiian needs.

e. Alcoholism and other chemical dependancies.

In 1979, Native Hawaiians comprised 19.4% of alcohol abusers, ranking second to haole (40.6%). In the alcohol treatment population, Native Hawaiians were 10.2%, second to haole who were 70.8%.

Of drug abusers, 22.3% were Native Hawaiians, after haole who were 49%. Among the drug abuse treatment population, Native Hawaiians ranked first with 44.4%. No special attention has been given to this major Native Hawaiian health problem.

12. Suicide.

a. Beginning in the period 1958-1962, Native Hawaiian males had the highest suicide rate of 16.1/100,000. During the years 1968-1972, overall, Native Hawaiians had the highest suicide rates. The most striking figures were for young Native Hawaiian males, 15-24 years, which ranged from 26.81 to 52.98/100,000.

b. These findings support the hypothesis that the despair of

cultural conflict with loss of Hawaiian cultural identity continues. No special attention has been given to this important Native Hawaiian health problem.

13. Medical care.

a. Care of sick Native Hawaiians has not been systematically assessed.

b. Although the Queen's Hospital in 1859 and the Kapi'olani Hospital in 1890 were founded for Native Hawaiians who initially received free medical care, this policy is no longer in force. Lunalilo Home for elderly and destitute Native Hawaiians also does not provide free medical care. Native Hawaiians receive no special formal medical attention in their native land, perhaps because U.S. civil rights laws prohibit racially-segregated health care. However, American Indians on reservations are eligible for free medical care.

c. As other U.S. citizens, Native Hawaiians pay directly for medical care, purchase health insurance, or acquire Medicaid and/or Medicare coverage if they are eligible. Statistics are meagre; however, Native Hawaiians appear to be underrepresented for Medicare and HMSA, and overrepresented for Medicaid.

d. In 1968, a majority of interviewed Native Hawaiians in Nanakuli were reluctant to use haole medical and dental services.

In 1977 in some communities, Native Hawaiians considered medical services to be unknown, not readily accessible, or not optimal.

Native Hawaiians displayed distinctive patterns of behavior in: degree of spirituality, reverence for nature, preference for living off the land and sea, child-rearing, respect for elders, affiliation, sensitivity to the moods of others, avoidance of

confrontation, and "no big ting" (minimization to avoid risk).

Hale Ola o Ho'opākōlea at Nānākuli, QLCC windward unit on O'ahu, and Dr. Emmett Aluli's barefoot physician's approach on Moloka'i provided new models for health care: Wai'anae Na Keiki O Ka 'Āina Farm Project, Nānākuli Youth Agriculture Project, Wai'anae O'pelu Project, Waimānalo Teen Project, Kokua Lima, and Hale Lōkāhi are further examples of Native Hawaiian programs related to health.

Six basic values pertaining to health at Hale Ola are: Kuleana (responsibility), aloha (affection), ho'omanawanui (patience), lōkāhi (unity), laulima (many hands working together), and kōkua (help).

e. Health education for Native Hawaiians has been sparse. In 1977, the Kamehameha Schools began its Kupulani research-demonstration project for assisting Native Hawaiian families to nurture adaptive learning skills and attitudes in their preschool children, beginning at pregnancy through school entry at age 5. Results have yet to be published.

f. In 1974, because of evidence that Hawaiians were among the ethnic groups underserved by some Department of Health programs, the U.S. Department of Health & Human Services in 1976 cited the Hawaii State Department of Health as being "in non-compliance with the Civil Rights Act of 1964."

14. Health professionals.

a. Physicians.

Since 1977, reliable data are not available on the number of Native Hawaiian licensed physicians in the state. In 1980, of the about 2,000 licensed physicians in the state, less than 50 (2.5%) were believed to be Native Hawaiian.

b. University of Hawai'i-Mānoa, John A. Burns School of Medicine.

In 1967 when the first class of 25 students were admitted to the then 2-year medical school, none was Native Hawaiian.

Since 1975, when the first class was awarded MD degrees, 52 (7.4%) out of a total of 703 graduates have been Native Hawaiian. Most of these graduates have completed residency training. In each current class there are 5-11 Native Hawaiian students out of 60-70 students. No study has been made of their placement in predominately Native Hawaiian communities.

c. Nurses.

No information is available on the number of nurses in the state who are Native Hawaiian.

The University of Hawai'i-Mānoa, School of Nursing estimates (figures are not recorded) that at any one time, about 3% of their students are Native Hawaiian. From 1956-1985, 110 Native Hawaiians have entered the University of Hawai'i-Mānoa, School of Nursing program but no figures have been kept on how many have been graduated. In the 1984-85 class there are 5 Native Hawaiians out of 11 minority students. In the 1985-86 class there are 7 Native Hawaiians out of 12 minority students. The total number of students in the 1984-85 Bachelor's Degree program was 194. The total enrollment for this same program for the fall of 1985 is 151.

d. Public health.

In 1983, the state Department of health provided figures indicating that 12% of their employees were Native Hawaiian. This is about 7% underrepresentation.

The University of Hawai'i-Mānoa School of Public Health reports that since 1977, 17 (1.5%) of 1,130 graduates have been Native

Hawaiian. In 1985, 3 (1.8%) of 169 admitted students were Native Hawaiian. Since a special Health Career Opportunity Program aimed at Native Hawaiians, Samoans, Filipinos and Micronesians was started in 1979, little progress has been made in increasing the number of Native Hawaiian professionals.

e. The University of Hawai'i-Mānoa School of Social Work does not keep statistics on the number of Native Hawaiian students in its Masters of Social Work program.

f. In all major health professions for which data are available, Native Hawaiians are seriously underrepresented. Although some efforts have been made through federal equal opportunity and affirmative action programs to correct these inequities, little progress has been made, and without steady improvement. Education in these professions is haole in orientation. Cross-cultural aspects are explored in some courses in the University of Hawai'i-Mānoa School of Public Health, and in the Department of Psychiatry in the John A. Burns School of Medicine, at the University of Hawai'i-Mānoa campus but apparently not elsewhere. The need is not only for more Native Hawaiians in these disciplines, but for Native Hawaiians who are culturally sensitive to their underserved people. How sensitive new health career graduates are, and how motivated they are to serve in Native Hawaiian communities have not been assessed.

D. Previous responses to Native Hawaiian health needs.

1. These have not been systematically examined. They include:

In 1859, founding of the Queen's Hospital by Kamehameha IV and Queen Emma with free haole medical care for Native Hawaiians.

In 1880, the Ho'oulu a Ho'ola Lāhui Society survey which led to

Kapi'olani Home for daughters of leprosy patients, and later the founding of the Kapi'olani Maternity Home.

In 1909-1911, the illfated U.S. Leprosy Investigation Station at Kalawao, cited in a previous section.

In 1914, the Hawaiian Protective Association, Pu'uhonua Society, Hui Po'ola and United Hawaiian Association reports on insanitary urban living conditions for Native Hawaiians which initiated in 1920, the Hawaiian Homes Commission Act, described in an earlier section.

The 1910-1922 speeches and writings of Reverend Akaiko Akana, Prince Kūhiō, Hawai'i Territorial Senator John Wise, and attorney Noa Aluli.

2. The present report appears to be the third in modern times.

The first, in 1977, was a health needs assessment by Alu Like, Inc., founded as a Native American agency for Native Hawaiians in 1976.

The second was the 1983 Native Hawaiians Study Commission Report's health section, most of which was buried in small print in the report's appendix. The U.S. Congress has yet to respond to the report's recommendations.

3. There has been only scant discussion of Native Hawaiian health matters in the Native Hawaiian, health, and academic communities and in the communications media, prior to the E Ola Mau Conference on November 1, 1985.

4. Similarly, actions have been meager, such as the Office of Hawaiian Affairs' rehabilitation program for alcoholic Native Hawaiian men at Hina Mauka in Kāne'ohe, a dental health proposal for Headstart children in 1984, and \$100,000 appropriated by the 1985

State Legislature for research on cancer in Native Hawaiians.

IV. Conclusions

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

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

C. Western impact, beginning in 1778, resulted in spiritual devastation and almost complete eradication of the Native Hawaiians.

The main factors in this decimation were introduced infections, native hypersusceptibility and lack of immunity, and haole (white) economic, political, social, cultural and military control, with resulting Native Hawaiian despair and, for many, loss of will to

live in a world that had become hostile and no longer meaningful.

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

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

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

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

mele (song), hula (dance), other arts and crafts, lawai'a (fishing), mahi'ai (farming), and lapa'au (Hawaiian medicine).

F. Two main options appear available:

1. Continue to ignore Native Hawaiian health problems as has been usual in the past.

Two subsets of po'e Hawai'i will emerge:

- a. Native Hawaiians who will undergo further de-Hawaiianization and become assimilated as non-Native Hawaiians, even though they may occasionally be identified as Native Hawaiians.

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

- b. Native Hawaiians who will continue as the landless, dispossessed, culturally-confused, sick, and thus, will persist as "the Native Hawaiian problem."

2. Kāko'o (support) Native Hawaiians in furthering our spiritual and cultural identity, so that through our improved coping skills, self-esteem and support systems for political self-determination and economic self-sufficiency, we may regain our land base for pursuit of more meaningful lives and thus, improved well-being, including health.

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

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

V. Recommendations

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

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

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

1. Input by ka po'e Hawai'i in all stages of planning and implementation, with the goal of control by Native Hawaiians

ourselves in programs for ourselves. If "none are qualified," then prompt on the job training should begin. This also includes respect for Native Hawaiian sensitivities in the process and use and strengthening of existing Native Hawaiian networks and support systems.

2. Build upon current Native Hawaiian cultural strengths by incorporation of appropriate mea pono Hawai'i (valid Native Hawaiian values and practices), such as the basic concept of lōkāhi with the cosmos, self, others, land and sea, and 'aumākua in nurturing and maintaining mana; and 'olelo Hawai'i (Hawaiian language) as essential to restoring and maintaining our culture, and thus, our health.

3. Monitoring to assure that programs are of definite benefit to ka po'e Hawai'i, and not merely for promoting non-Native Hawaiian researchers and sustaining administrative bureaucracies.

C. Systematic and continuous collection, tabulation, and analysis of critical health data by Native Hawaiians on Native Hawaiians for health needs assessments and specific health programs for Native Hawaiians, with the setting of priorities based on importance of need, expertise available, receptiveness of ka po'e Hawai'i, and availability of funds and other resources.

The appropriate agency for these important tasks needs to be carefully determined.

D. Definition of realistic, practical and meaningful goals.

1. Emphasis on health-promotion in the holistic sense, disease-prevention and control within appropriate cultural contexts, rather than exclusive end-stage intervention in hospitals.

2. Instead of mere improvement of health statistics, such as

prolongation of life expectancy of ka po'e Hawai'i to that of haole, with nursing homes for abandoned elderly, we should realize that modern haole lifestyle factors may be largely responsible for illhealth of ka po'e Hawai'i; and haole standards are not necessarily ideal or appropriate for ka po'e Hawai'i.

3. Avoidance of simplistic, romantically-idealized, politically-expedient "solutions," that are at high risk for failure, such as the folly of the U.S. Leprosy Investigation Station at Kalawao from 1909 to 1911, and the Hawaiian Homes Rehabilitation Act of 1920.

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

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

dependence on professionals.

F. Education of health personnel.

1. Of culturally-experienced and sensitive Native Hawaiians.
2. At all levels beginning with hiapo (eldest sibling), mākua (parents, uncles, aunts), kūpuna (grandparents, elders), as teachers among peers and to juniors, within extended 'ohana and local Native Hawaiian community existing social support networks.
3. Education of Native Hawaiian health professionals, to include not only physicians and nurses, but health educators, health aides, health advocates, health coordinators, health planners, health researchers, and health administrators.
4. Support appropriate training of respected native healers.
5. Native Hawaiian cultural-awareness training of non-Native Hawaiian health professionals.

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

1. Appointment of Native Hawaiian health administrator in Hawai'i State Department of Health, at the state level and for each county, to coordinate government health programs for Native Hawaiians with non-government programs, to avoid unnecessary duplication and to fill the gaps, maintain continuity and stability of needed and effective programs, and discontinue ineffective ones.
2. Native Hawaiian community inter-disciplinary Hale Ola (local family health centers) with local governing boards to assure availability, accessibility, acceptability within appropriate cultural context, focused on health-promotion and holistic medical care.

Some suitable models include: Hale Ola Ho'opākōlea, Hale Lōkāhi,

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

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

H. Integration of health programs with others concerned with:

1. Land: Regain and maintain Native Hawaiian land base through federal reparations for U.S. illegal overthrow of the kingdom and violation of Native Hawaiian indigenous people's rights. Return of federal ceded lands, pressure for state ceded lands and the Hawaiian Home lands, and proper protection of private Native Hawaiian lands, such as the Bishop Estate, Lili'uokalani Trust, Queen Emma lands, and threatened private Native Hawaiian family lands. Proper use of Native Hawaiian lands for Native Hawaiians: homes, access for farming, fishing, hunting, wood and plant-gathering; Native Hawaiian community facilities, such as pā and marae (enclosed clearing), for Native Hawaiians' 'aha (gathering), hālāwai (meeting), hō'ike (show), celebrations, ceremonies; and for human services for Native Hawaiians.

2. Population control of further in-migration to prevent further

unhealthful crowding and its other consequences, such as crime and destruction of natural resources.

3. Law: State civil rights law to assure representative health care for po'e Hawai'i.

Laws to restrict sale and use of harmful substances, such as tobacco, alcohol, and specified harmful processed foods.

Education of more Native Hawaiian culturally-sensitive attorneys, legal aides and mediators, with their placement in needed Native Hawaiian communities. Workshops on Native Hawaiian rights.

4. Political self-determination: Locally-elected Native Hawaiian councils and governing boards.

Representation of po'e Hawai'i on all government bodies.

Workshops on political organization and effective action on Native Hawaiian issues. Register every eligible Native Hawaiian to vote; provide transportation to voting booths.

5. Economic self-sufficiency: Job-training, especially for self-sufficiency in living from the land and the sea (vide infra - see below).

Native Hawaiian banks for loans at low interest to po'e Hawai'i.

Restraints on foreign multi-national control of Hawai'i economy and especially of Native Hawaiian lands.

6. Environmental protection against pollution and destruction of our natural resources by government, developers, tourism, other commercial interests and the military.

7. Education: Hawaiian language and culture in all public and private schools, with instruction on Native Hawaiian rights and history of exploitation of Native Hawaiians, coordinated with health instruction at all levels.

Increased alternative education programs for Native Hawaiian school age youngsters incorporating health instruction within Native Hawaiian cultural context.

8. Housing: Preference for needs of local Native Hawaiians over desires of malihini (newcomer) and greed of developers.

Incorporation of appropriate Native Hawaiian design and architecture by Native Hawaiians in all construction for Native Hawaiians.

9. Transportation: Limitation on automobiles and roads to reduce auto-related morbidity and mortality, and restrictions on destructive air and sea transportation facilities and practices.

10. Energy: More use of natural energy sources; less dependence on foreign oil.

11. Historic sites: Protection, restoration, maintenance and proper cultural use of Hawaiian historic sites in regular celebrations, ceremonies, cultural 'aha (gathering), and historical dramas.

12. Communication: Appropriate representation (about 20%) of Native Hawaiian culture, language and personnel in all major media (TV, radio, newspapers).

Restriction of commercial advertising of health-harmful marketed products.

13. Lawai'a (fishing): Restoration of na loko (fishponds) to be maintained by po'e Hawai'i; subsidized cooperative lawai'a until such programs become self-sustaining. Appropriate nurturing and protection of Native Hawaiian marine food sources.

14. Mahi'ai (farming): Subsidized cooperative, diversified mahi'ai for local needs, engaging Native Hawaiians, until farming programs become self-sustaining; promotion of individual home gardens, and small-scale farming for family subsistence of Native Hawaiian food

sources, such as, taro, 'uala (sweet potato), uhi (yam), 'ulu (bread-fruit), mai'a (banana). Models include Ka'ala and Makaha farms.

15. Language and culture: 'Aha Punana Leo (language nest) for preschool, child-care Native Hawaiian culture-language centers, conducted by trained Hawaiian language speakers and incorporating traditional Native Hawaiian cultural concepts, literature, and practices. Thus, a new generation of Native Hawaiian language speakers will replace the few remaining elderly ones.

(References are available upon request)