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Conversations with Pacific Islanders

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Contents

Health Disparities Among Pacific Islanders

Within the United States, Hawai'i is the best known of the Pacific Islands. However, a number of other islands are associated with the United States politically or historically. They are dispersed across both the North and South Pacific in a vast stretch of territory encompassing thousands of miles. These include Guam, American Samoa, Midway Islands, Wake Island, Johnston Island and Sand Island, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands.

A wide array of ethnic subgroups live on these islands, including the *Kānaka Maoli*, or Native Hawaiians, on Hawai'i; the Chamorro of Guam; the Chuukese, Yapese, Pohnpeian and Kosraean of the Federated States of Micronesia; the Mariana Islanders; the Marshallese; the Carolinians; the Palauans; and the Samoans.

Despite a rich cultural history, spanning milenia, and distinctions between each island's traditions and populations, Pacific Islanders remain "one of the smallest and most poorly understood groups of minority persons."[1] In the United States, this has been due at least in part to a quirk of data collection, which until recently subsumed Pacific Islanders under the broader category of Asian American/Pacific Islanders (AAPI). Since Pacific Islanders represent just 5 to 6% of the larger group, their demographic trends and health needs were often overshadowed by misleading data depicting the group as a whole.

In 2000, for the first time, the U.S. Census data collection forms gave respondents an option of reporting their race as Native Hawaiian, Guamanian or Chamorro,

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[1] Wergowske, G. L., P. L. Blanchette and J. H. Diaz. Aging and Health Among Pacific Islanders. *Clinical Geriatrics*. From website: www.mmhc.com/cg/articles/CG9906/Blanchette.html. Accessed 3/4/03.

Samoan, or (by filling in a blank space) "Other Pacific Islander."[2] Of the total U.S. population of 281 million, 874,000 people, or 0.3% of the total population, reported their race as Pacific Islander, alone or in combination with one or more other races. A total of 399,000 people (or 0.1%) reported their race as Pacific Islander only. The most common combinations were Native Hawaiian, Other Pacific Islander and Asian (29%), followed by Native Hawaiian, Other Pacific Islander and white (24%).[3]

The census data showed that the largest Pacific Islander group living in the United States was Native Hawaiians, accounting for 401,000 of those who reported some type of Pacific Island race (alone or in combination with others). The next two largest groups were Samoans (133,000) and Guamanian or Chamorro (93,000). Together, these three groups account for 74% of all Census respondents who reported a single Pacific Islander race as their own, and for 71% of those who reported combinations of Pacific Islander races.

Demographic Characteristics

Pacific Islanders are a young population and a fast-growing segment of the U.S. population. In 1999, 29% of Asians and Pacific Islanders were under the age of 18, compared to 24% of whites.[4] In 1990, the median age for Pacific Islanders ranged from 22 for the youngest group (Samoans) to 26 for the oldest group (Hawaiians). Nearly half the population in all the islands is under 19. In Micronesia, the majority of the population is under 15.

In 2000, nearly three-quarters (73%) of Pacific Islanders in the United States lived in Western states, with 58% concentrated in California and Hawai'i. Another 14% lived

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[2] Between 1960 and 1980, Census forms gave residents of the state of Hawai'i an option of identifying themselves as "Hawaiian" or "Part Hawaiian." Between 1970 and 1980, "Hawaiian" was added to state census questionnaires. In 1990, respondents could choose "Other Asian or Pacific Islander."

[3] Grieco, E. 2001. The Native Hawaiian and Other Pacific Islander Population: 2000. *Census 2000 Brief.* U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau.

4Humes, K., and J. McKinnon. 2000. The Asian and Pacific Islander Population in the United States: March 1999. *U.S. Census Bureau, Current Population Reports,* Series P20-529. Washington, DC: U.S. Government Printing Office.

in the South, 7% in the Northeast, and 6% in the Midwest. Pacific Islander populations are concentrated in Honolulu, New York, Los Angeles and San Diego.[3]

Pacific Islanders experience relatively high poverty rates. In 1989, 17% of Pacific Islanders (58,000 people) lived below the federal poverty level, compared to 14% of Asian Americans/Pacific Islanders overall. Samoans had the highest poverty rates, with one out of four Samoan families living in poverty. An April 2002 report on health disparities noted that the percentage of children living in poverty had improved for every ethnic group except Asians and Pacific Islanders.[5]

Approximately a quarter of Pacific Islanders over age 5 speak a language other than English at home. A third report that they do not speak English very well, and 11% are "linguistically isolated." These rates are highest among Samoans, and lowest among Hawaiians.[6]

Health Status of Pacific Islanders and Access to Health Services

Relatively few studies have examined the health status of Pacific Islanders in detail, although new initiatives are beginning to fill this gap. We do know that as a group, Pacific Islanders suffer disproportionately from diabetes and cardiovascular disease, both of which are preventable conditions.

Between 1980 and 1990, the mortality rate for heart disease improved for all races combined, but worsened for Hawaiians. Heart disease is the leading cause of death for Native Hawaiians and is 66% higher than the heart disease mortality rate for the rest of Hawai'i's population.[6] Likewise, a more recent study of the prevalence of diabetes and glucose intolerance among Native Hawaiians in two rural communities

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[5] American Public Health Association. 2002. Health disparities improve in U.S., but still significant: Gains found for all races, ethnicities. *The Nation's Health* (April).

[6] National Institutes of Health. 2000. *Addressing cardiovascular health in Asian Americans and Pacific Islanders: A background report.* NIH, National Heart, Lung, and Blood Institute (NHLBI) (NIH Publication No. 00-3647).

found prevalence rates four times higher than those among non-Hispanic whites.[7] Data on diabetes rates in Hawai'i between 1988 and 1995 show rates among Native Hawaiians that were double those of non-Hispanic whites.[8]

Both diabetes and heart disease are linked to the underlying risk factor of obesity. A combination of sedentary lifestyles and high-fat diets contribute to this trend throughout the Pacific Islands. In Hawai'i and in other islands, studies have suggested that a return to traditional diets, focused on staples such as taro, breadfruit, and sweet potato, could help lower serum cholesterol levels. Instead, dietary habits like those in Micronesia, where residents rely on canned meat, shortening, and salty, canned fish, contribute to excess heart disease mortality.[6]

The fact that Pacific Islander populations are relatively young offers hope for health education and health promotion efforts that aim to change dietary and physical activity patterns. Successful programs in these areas could help reverse the escalating and deadly trends of heart disease and diabetes.

However, other potential challenges are far more complex. The combination of high poverty rates, lower family income, and linguistic isolation found in many Pacific Islander communities creates significant obstacles to health care. Physically reaching a health center—not to mention filling prescriptions or having access to specialists—is a logistical hurdle for many Pacific Islanders, especially in rural areas.

Even when Pacific Islanders do gain access to care, their experiences are not encouraging. A recent study of Asian Americans and Pacific Islanders who received managed health care from 48 physician groups in California, Washington, Oregon, Texas, Arizona and New Jersey found that Asians and Pacific Islanders were consistently the largest group giving their health plans poor ratings on a range of

[7] Grandinetti, A., H. K. Chang, M. K. Mau, J. D. Curb, E. K. Kinney, R. Sagum and R. F. Arakaki. 1998. Prevalence of glucose intolerance among Native Hawaiians in two rural communities. *Diabetes Care* 21 (4): 549-554.

[8] National Diabetes Information Clearinghouse. 1999. *Fact sheet: Diabetes statistics.* NIH Publication No. 99-3926. Washington, DC: U.S. Government Printing Office.

access measures. These included getting through to staff by telephone, scheduling appointments, accessing specialists, getting laboratory tests or exams ordered, and getting referrals for mental health care.[9]

The U.S. Department of Health and Human Services has found the U.S. Pacific Territories are medically underserved, with a physician-to-population ratio of about 1 to 3,000.[10] Few Asian or Pacific Islander physicians practice where Pacific Islanders live, limiting the availability of culturally competent providers. The Native Hawaiian Health Scholarship Program is one attempt to redress this imbalance. The Ahahui On Na Kauka, formed in 1998, is an association of 140 Native Hawaiian physicians that will hold its first major conference in 2003.

Health Disparities

The movement to reduce and eliminate health disparities is one that has been gaining momentum on both global and domestic fronts. At a global level, it is part of a broader notion of health articulated in 1978 at the International Conference on Health Promotion in Alma-Ata, which declared that:

> "...health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."[11]

Closer to home and more recently, an Institute of Medicine report that chronicled lower quality of care for minorities identified specific actions to reverse these trends

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[9] Snyder, R. E., W. Cunningham, T. T. Nakazono and R. D. Hays. 2000. Access to medical care reported by Asians and Pacific Islanders in a West Coast Physician group association. *Medical Care Research and Review* 57 (2): 196-215.

[10] U.S. Department of Health and Human Services. 1997. *Healthy People 2000 progress review for Asian Americans and Pacific Islanders: Briefing book.*

[11] World Health Organization. 1986. Health promotion: A discussion document on the concept and principles. *Public Health Reviews* 14 (3-4): 245-254.

at the clinical level. These include training and deploying more minority health care providers, increasing the ranks of interpreters available to patients in neighborhoods where these needs are most common, and increasing the availability of community-based health workers who can help patients navigate complicated systems. The report's authors also recognized that, while patient education and support can help minimize communication problems, the burden falls on providers to improve their interactions with patients, through training that helps them understand different cultures. More research is needed to identify both sources of health disparities and promising interventions to combat them—and especially to understand the role and prevalence of bias, prejudice and stereotyping.[12]

At a broader federal level, *Healthy People 2010*, the U.S. Department of Health and Human Services' health objectives for the Nation, calls for eliminating health disparities within the decade by concentrating on six conditions and diseases where the gaps between minority and mainstream health outcomes are the most glaring and persistent:[13]

Infant mortality
Cancer screening and management
Cardiovascular disease
Diabetes
HIV/AIDS
Child and adult immunizations.

The previous iteration of Healthy People, setting forth goals for 2000, called for reducing disparities—a goal that was ambitious, but fell short of the current goal of eliminating disparities.

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[12] Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. 2002. *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press.

[13] U.S. Department of Health and Human Services. 2000. *Healthy people 2010: Understanding and improving health*. 2d ed. Washington, DC: U.S. Government Printing Office.

The voices chronicled in this monograph capture the optimism and urgency behind that goal. They include Dr. Kekuni Blaisdell, who was instrumental in creating the E Ola Mau Study that first profiled Hawaiians' poor health nearly two decades ago. He helped to found Papa Ola Lokahi and the Native Hawaiian Health Care Systems.

Puaaloakalani Aiu, Faye Untalan and Merina Sapolu who have each contributed to this monograph, embody this commitment. So do the participants in the discussion group led by Dr. Untalan.

Dr. Eliuel Pretrick works as Director of Health, Education and Social Services in the Federated States of Micronesia. His interview here demonstrates his dedication and serves as an inspiration to anyone concerned with Pacific Islander health.

The founding mothers of Pacific Island health also deserve acknowledgement. These women looked to community as the source of their strength and healing. Thanks to their efforts, community input is considered the norm when doing research in the Pacific Islander community. Ho'oipo DeCambra, Claire Hughes, Fern Clark and JoAnn Tsark are not interviewed in this monograph but their contributions are significant nonetheless.

Mr. Myron Thompson, whose vision helped to create and guide Papa Ola Lokahi for the past 10 years, must be also be given credit. Although he is no longer with us, he left the Hawaiian people a legacy of improved health, wellness and safety through the many programs in health, social services and long-distance voyaging that he helped to create.

We hope that a decade from now, the Pacific Islanders profiled here will have led the way to a greater understanding of the health status of Pacific Islanders and, most important, to closing the gap in health disparities that persist across the Pacific.

Bringing Health Back to the Community

NELLIE RISING SGAMBELLURI

NELLIE RISING SGAMBELLURI, MPH, *was born and raised in Santa Rita, Guam. She has a master's degree in public health from University of California, Los Angeles, and is currently pursuing a medical degree at the John A. Burns School of Medicine at the University of Hawai'i, Mānoa.*

She served as the director of health projects at the Guam Communications Network in Long Beach, California. In Hawai'i, she has worked as an asthma educator for the American Lung Association and has helped conduct research about perceived barriers to prenatal care for low-income mothers. She has also worked for the CDC REACH 2010 Breast and Cervical Cancer Project, Census 2000 Outreach and is a fellow with the Asian Pacific Partners for Empowerment and Leadership. She hopes to one day found a health center in southern Guam to provide culturally appropriate, comprehensive health care to the local community.

AS A YOUNG CHILD, I HAD VERY LITTLE CONTACT WITH DOCTORS OR OTHER HEALTH PROFESSIONALS. However, at age 12, I experienced a tragedy that introduced me to the health care field. My aunt died of cervical cancer. I stayed with her during her last month of life and watched her pass all the nutrition and blood pumped into her onto the sheets. While I hoped for her recovery, a little bit of the emerging adult in me knew that her death was inevitable. What saddens me most is that she could be alive today if she had received culturally sensitive preventive care.

At the time, it did not occur to me that I could play a role in preventing these types of tragedies in other families by working in the health field. In fact, it wasn't until attending college at UC Berkeley that I considered a career in health.

Discovering the Possibilities

The winter of my freshman year, I went to the student health center for a bronchial infection. For the first time in my life, the doctor talked with me for more than two minutes. She educated me about my body and the effects of not finishing the full course of prescribed medication. She also gave me a choice of possible treatments for my infection.

To my surprise, I felt satisfied by the visit. I realized then that doctors could work with patients as partners and empower them to make decisions about their own health and well-being. I thought that this was something that I would like to do but I didn't know much about how to become a doctor or what other options there were in the health field.

I searched for guidance by taking a course in medical ethics. The class challenged me to critically analyze opinions I held about issues ranging from euthanasia to national health care. The 600-student class is run by a student group named the Health and Medical Apprenticeship Program (HMAP). HMAP also places undergraduate interns in the public health and medical fields. I loved the program so much that I stayed as a teaching assistant for five semesters and served as the assistant administrative coordinator in my last semester.

I also organized a lecture on Women in Medicine. I had the opportunity to speak with physicians, professors, public health professionals and community activists. From this experience, I decided that I'd make a difference in my community by serving as a primary care physician who emphasizes health education, prevention and teamwork—between patients, communities and other health professionals.

Working in the Field

After graduating from UC Berkeley, I decided that I should pursue a master's degree in public health. I also felt that I should get some experience working in the health field, specifically in the Pacific-Islander community. So, I entered the MPH program at UCLA and focused my studies on the sociocultural aspects of community health sciences. I learned about program planning and evaluation—essential skills for starting programs that incorporate medicine and public health in an underserved area with limited resources. I learned that the need for accurate and complete data in Pacific-Islander communities is great, and pursued projects that allowed me to learn how to address these concerns.

However, the most valuable experience I gained during my time in Los Angeles was working at the Guam Communications Network (GCN) in Long Beach, California, as the Director of Health Projects. GCN is a nonprofit organization run by Lola Sablan Santos. Through the efforts of Lola and many community members, GCN manages a variety of health and social programs that address the needs of the Pacific-Islander community of Southern California.

Lola allowed me flexibility to write grants and start programs in areas where I had the most interest. She introduced me to the leaders of health programs and was always finding opportunities for me to go to conferences where I could meet Pacific Islander community leaders on a national level. Lola always encouraged me to pursue my goal of becoming a physician and pushed me to take every opportunity to meet those who could help me to make my dreams a reality.

My work experience has been invaluable for understanding the needs of my community and gaining skills toward better health care for our people. I have started addressing health disparities through my work with the Centers for Disease Control and Prevention REACH 2010 Breast and Cervical Cancer Project. REACH—Racial and Ethnic Approaches to Community Health—is a federal demonstration program which specifically addresses ways to eliminate health disparities among different ethnic communities. I have also worked with Census 2000 outreach in an effort to increase reporting and obtain higher quality data for Pacific-Islander communities. I've attended town hall meetings with delegates from the White House Asian and Pacific Islander Initiative and I've pushed for increased funding for the training of community health professionals.

I've become a fellow with the Asian Pacific Partners for Empowerment and Leadership, where I work to combat the effects of tobacco in our communities. I've also been a guest speaker at numerous conferences, addressing specific health care concerns in Pacific-Islander communities and the need for culturally sensitive providers. At the National Asian Pacific American Medical Students conference, I gave recommendations for how physicians can work toward addressing these needs. I have gained credibility in the Pacific-Islander community of Los Angeles County as a community grassroots organizer and as a health professional working on multiple projects that aim to prevent or control chronic disease.

A Dream for the Future

I was sad to leave the Guam Communications Network when the time came for me to attend medical school at the John A. Burns School of Medicine at the University of Hawai'i, Mānoa. As a health professional, I hope to be able to contribute to the reduction of health disparities in Pacific-Islander communities, especially in the area of chronic disease. I'd like to focus much of my work on disease prevention and providing other culturally appropriate, state-of-the-art health services.

I aim to practice medicine in a community-based clinic located in the southern part of Guam, where there are few health professionals and health care facilities. I envision myself working within the community to combat the health and social issues they identify as barriers to health care access. I hope to integrate public health and medicine in an effort to bring together the strengths of each profession for the benefit of my community.

My ultimate goal is to start a health center on the southern part of Guam like the Waianae Coast Comprehensive Health Center on Oahu—a health center that is community founded, locally run, and provides quality, culturally appropriate comprehensive health care. I feel that if we each work to build the infrastructure of our communities and conduct research into the reasons for health disparities and how to address them, we will improve the health and well-being of our people—the goal for which many of us, as health professionals, strive.

A Hawaiian Agenda: Health at Home

Puaalaokalani D. Aiu

Puaaloklani D. Aiu, PhD, *is currently a policy analyst with the Office of Hawaiian Affairs. Previously, she was the Research Officer, Papa Ola Lokahi, where she worked with statewide and national agencies to ensure that Native Hawaiian health issues were addressed. She administers a Native Hawaiian HIV/AIDS case management program, and works with the Native Hawaiian Health Care Systems to ensure their issues are heard at the state and national level. Her work includes grant writing, program development, and work to ensure compliance with the Federal Native Hawaiian Health Care Act regarding Native Hawaiian Health Care Systems.*

She was named by the Deputy Secretary of Health and Human Services to serve as the Community Coordinator for Native Hawaiians for the HHS Asian and Pacific Islander Initiative. As a Health Planner from 1992 to 1993, she worked with statewide agencies to develop programs to address Native Hawaiian Health. She holds a BA from Pomona College, an MA from University of California, Santa Barbara, and a PhD in Communication from the University of Massachusetts, Amherst.

Who has inspired your work?

My dad is a doctor so health was always important. He was the first gynecologist on Kauai. He moved back to Kauai and took a lower salary than he would have had in Oahu because he wanted to work in a rural area with the people he grew up with.

My Auntie Davianna is kind of an activist. She's a professor at the University of Hawai'i and very much into Hawaiian issues. She took all of her nieces and nephews with her to all of her activist rallies, much to the amazement of my parents and my uncles and aunties. She's always encouraged us to get involved in Hawaiian activism.

When I came back from graduate school, I worked for Papa Ola Lokahi, which is our Native-Hawaiian health care system, so that I could work for Hawaiians in health.

What are some of the lessons you have to share with others?

It's really frustrating to work with Hawaiians because they are a very frustrated population. They've been forced into this sort of new world order and they don't always want to be there. There's an experience of victimization at times.

As a provider, you have to be patient. You also have to know where you want to go so that you don't get caught up in the politics of some of the issues. That statement will probably get me into trouble but I really think that if you want to accomplish things you have to have a vision, and not be swayed by politics and the loud voices on either side of your path.

If you want to accomplish things you have to have a vision, and not be swayed by politics and the loud voices on either side of your path.

Many programs, policies and reports put Asians, Pacific Islanders, Hawaiians and Filipinos together, particularly in terms of health issues. What is the importance of holding Hawaiians separately?

One of the main things is that Hawaiians are an indigenous people, not immigrants. So when you put Asians and Pacific Islanders and Hawaiians in one group, then Hawaiians get treated as if they're immigrants. Certain issues such as welfare reform, for example, and the ways this affects immigrants, are really important to Asians. Because the Asian population is bigger, this can become the main thrust of what's going on. The other issue that Asians have because they're an immigrant population is the language issue—making sure people receive linguistically appropriate health care. But Hawaiians are not an "English as a second language" population and welfare restrictions for immigrants don't affect us.

So a lot of the programs don't address our issues. That's one of the main reasons it's really important to be distinct.

Another part of it is that statistically we're different. Hawaiians have different health disparities, and their high-incidence diseases are not the same as Asians'. When you look at certain segments of the Asian population economically, they're really better off. In fact, some segments are statistically doing better than Whites in some areas. That's not true for Hawaiians and it's really not true for Pacific Islanders.

Hawaiians have different health disparities, and their high-incidence diseases are not the same as Asians'.

These distinctions between the Asian population, the Native-Hawaiian population, and the Pacific-Islander population get masked if you group them together.

What have your life experiences allowed you to accomplish?

I come from a fairly well-known family. My auntie Davianna is well known because she has consulted on a lot of Hawaiian issues. She was very important in the return of Kahoʻolawe, a Hawaiian island used as a military target and training site in World War II. In 1993, the Hawaiian State Legislature set this island aside as a Reserve being held in trust for a future sovereign Native Hawaiʻi. No commercial use is allowed, only Hawaiian cultural, spiritual and subsistence uses. My auntie has written a lot of papers about Kahoʻ olawe, the Hawaiian sovereignty movement, Hawaiian culture, that are referenced. We used to joke when I lived with her that I saw her more on TV than at home.

Her partner, Dr. Emmett Aluli, who is really active in changing health care for Hawaiians, is my uncle. My father, Patrick Aiu, is from a prominent Kauai family and was the first gynecologist there. My mother, Danita McGregor, is from a fairly prominent Oahu family. My grandma was one of the first people to vote in Oahu. It helps to be from a well-known family in Hawaiʻi. That opens doors. But once you get in, you've got to prove yourself.

It helps to be from a well-known family in Hawaiʻi. But once you get in, you've got to prove yourself.

I was lucky when I was at Papa Ola Lokahi to work with Larry Miike who was at the Office of Technology. He worked for Senator Daniel Inouye when he was in D.C., so he was a really good mentor for me. Then Hardy Spoehr, who has worked in a lot of Hawaiian agencies (the Department of Hawaiian Homelands and also the Office of State Planning), was also a very good mentor. Here at Office of Hawaiian Affairs, I was fortunate to come into the Hawaiian Rights Division, so I have Colin Kippen as a mentor.

I've been really lucky in terms of the jobs and mentors that I've had. Because of my work at Papa Ola Lokahi, I got to work on the Asian/Pacific-Islander Initiative, which eventually became Presidential Executive Order 13125. And I got to meet a lot of people nationally who are involved in Asian/Pacific Islander health. I got to meet President Clinton.

What kinds of things have you been able to achieve?

When I was at Papa Ola Lokahi, they were part of a program—Special Programs for People with AIDS—which was designated a "Special Program of National Significance" under the Ryan White Care Act. This was a Native Hawaiian program for people with AIDS that's been somewhat institutionalized at both the Life Foundation on Oahu and the Maui AIDS Foundation. And I helped with that. We started a really exciting U.S. Indian Health Service project here on Oahu because we didn't have an Indian Health Service presence here.

I think I was lucky that I was one of the people who got to help with the Asian-Pacific Islander Health Initiative, along with a lot of people who came before me—JoAnn Tsark and Claire Hughes especially—who put Hawaiian health issues on the map in D.C.

What are the most important issues related to health disparities for Native Hawaiians?

Another important issue is preventive health for Hawaiians, because a lot of the diseases they have could be prevented with good diet or early care.

There remains the issue of access, which is not only an issue of insurance. A lot of people have insurance but they can't find a doctor they feel free talking to, or a doctor they can get to. The insurance issue is something totally different. Insurance is a money issue more than anything else. Another important issue is preventive health for Hawaiians, because a lot of the diseases they have could be prevented with good diet or early care.

Another important step toward eliminating health disparities is to be able to collect good data. For the first time, the Census is actually collecting data on Hawaiians. If you look at the 2000 publication, for example, there's no baseline data for Native Hawaiians. Now we need to collect some good baseline and follow-up data to see what works and what doesn't.

One of the things you're involved in now is land rights issues. Do you have thoughts about this in terms of health issues?

A lot of Hawaiians still live a kind of subsistence lifestyle, especially on the neighbor islands like the Big Island (the island of Hawai'i). The Kona Coast has been aggressively developed in a lot of areas. The people who once gathered from those lands suffered.

Hawaiians have certain specific gathering rights. Commercial interests cannot wantonly develop land or prohibit Hawaiians from gathering. Despite this rule, Hawaiians are going to have less of an ability to gather in developed areas.

So they're going to be less able to get fish from the ocean or *opae*—a kind of shrimp—from the brackish ponds. And they're going to be less able to gather medicines because those places just aren't going to exist anymore. Or, if they do exist, they're in a hotel setting and it's not going to be very comfortable to go and gather. That has an effect on their health because then they have to go buy canned goods because they don't have enough money to buy fresh foods. So then their diet changes. Studies have pretty clearly shown that when people go from a traditional subsistence diet to a "store-bought" diet their health does worsen.

Studies have pretty clearly shown that when people go from a traditional subsistence diet to a "store-bought" diet their health does worsen.

When I was a kid, my dad went diving a lot so we always had fresh fish. We didn't even know how to buy fish from the store. It wasn't an issue of money. It was just something my dad did. But now there's not as much fish, and there aren't many places you can go diving because the oceans are so crowded. That affects people's health.

Many people on the mainland are unaware of the Hawaiian sovereignty movement. How does the movement relate to Native Hawaiian health?

It's a very complicated subject. Let me give you the historical background. In 1893, there was a United States Minister to Hawai'i, John L. Stevens, who was friends with a group of white businessmen who were American expatriates. They had sugar interests and they wanted lower tariffs for their sugar. Also, they didn't like having a queen because that was a different kind of government than they knew.

With the help of Minister Stevens, in January of 1893, the American Marines landed in Hawai'i and occupied a position across from Queen Lili'uokalani's palace, pointing their guns at the palace. The queen ceded her authority to the United States to avoid bloodshed and was placed under house arrest. A provisional government was created—that was the group of businessmen. They were called the "Committee of Safety." Hawai'i was proclaimed a U.S. protectorate.

The Queen demanded that the U.S. government investigate the overthrow. President Cleveland sent out a person named Blount, a senator from the South. He found that the United States had participated in an act of war against a sovereign nation and had done so wrongly. The queen asked to be reinstated. However, she never got reinstated, in part because part of the deal would have been that she could not have Mr. Stevens or the "Committee of Safety" tried for treason, which would have brought the death penalty. Although President Cleveland believed the United States was guilty of wrongdoing and that the Queen should be restored as head of her government, he left office after only 4 years and it was never accomplished. Instead, McKinley became the president and the U.S. went to war—or was going to go to war shortly. Hawai'i became strategically very important, so McKinley annexed Hawai'i as a territory.

The people of Hawai'i never voted to become part of the United States. Hawai'i was annexed by the [1898] Newlands resolution. If you skip forward to 1993 which was the 100-year anniversary, President Clinton issued an apology for the United States' overthrow of the Hawaiian kingdom.

Right now there's a bill in Congress called the Akaka Bill that starts to redefine Hawaiians' relationship to the United States because there's an argument that Hawaiians should be treated like any other indigenous people of the nation, such as Native Americans. There are widely divergent views on whether we want to be treated like Native Americans or not because Hawaiians are not a tribe, and the whole history that the Indians have had with America is perhaps not a road we want to walk down.

There is definitely an active interest in reestablishing some sort of sovereignty, especially over land.

There is definitely an active interest in reestablishing some sort of sovereignty, especially over land. I truly believe that if you don't have the resources to live outside of the American system, then you're forced to live in the system. Native Americans and a lot of Hawaiians want to leave because the system was sort of forced on them. But if you don't have the resources, if the best fishing grounds were taken away from you, you have no control of the land or your destiny. If people don't want to belong to the system and want to fish for subsistence, or want to be able to practice traditional religious practices or to gather medicine or live in traditional ways, they need access to those resources. The way that Hawai'i is going now, the resources are being taken away faster than we can keep up.

Anything else you would like to say?

The kernel of it is that you have people who are...*disenfranchised* isn't exactly the word, but there's a dissonance between the way they have to live and the way they want to live. I think it's true in Native Americans as well. Because there's this dissonance, there are all kinds of health and social problems that you see in these populations. It's different from an immigrant population, because, unlike immigrants, they didn't make a choice to live in this system. They liked the way things were and this was forced on them. If you were to look at people who assimilate versus people who don't quite assimilate, you would find that when you have indigenous populations that have had to accommodate a new system, not all of them are ready to make that leap.

When you boil it down, it's an issue about the land and being able to live in a way that makes sense to you in your system of beliefs.

The political reality of how sovereignty is materialized is a whole other realm and it may not be a healthy realm. It may not lead to better health and well-being for Hawaiians because it's a whole political realm and you have a bunch of people who thoroughly believe in western styles of governance, or who believe you should go back to a queen, or who believe that they're the king. When you boil it down, it's an issue about the land and being able to live in a way that makes sense to you in your system of beliefs. Right now a Hawaiian system of beliefs and a western system of beliefs, or the American system of beliefs, just doesn't really work. How sovereignty materializes, what it's going to look like, may not answer all of our questions.

Based on your experience, what advice do you have for practitioners? What can they do to address and eliminate health disparities?

I suggest providers get their patients focused on preventive medicine or preventive care. That would be better for all of us. And diet especially would be an issue.

Papa Henry Auwae was a traditional healer. When he was alive he was into prevention. We used to have clinics for people with AIDS. He would tell them, "Unless you stop doing drugs and unless you stop eating this kind of food, I'm not even going to treat you. You need to live a certain way in order for me to be able to do anything for you." So, I think, prevention brings in the rules a culture has about what you can eat and when. At certain times of the year, for instance, you shouldn't eat certain fish because you'll start hallucinating. Maybe only a few people in the rural areas still remember these rules that have to do with prevention.

In some ways, western society doesn't support prevention because it values chasing after what makes you feel good. How do you explain prevention in a society that's telling you that? How do you make a kid stop drinking soda when it's so easily available and everybody's telling him, "If you drink soda you're going to be a good athlete or you're going to be popular," or whatever. The question is not how to do it in a Hawaiian context, because we don't have that context so much anymore, but how do you do it in the context of the world we live in now?

In some ways, western society doesn't support prevention because it values chasing after what makes you feel good.

What are your passions, visions and your hope for the future?

I would like to see Hawaiians and others emphasize land use that is sustainable rather than profitable. I do think it's related to health. People should have access to gathering resources. I'd also like to see some way to be able to implement prevention.

Stress is one of the big problems in our lives today. If everybody had more access to the beach and didn't have to go to really crowded ones, for example, maybe the stress levels for Hawaiians would go down a little bit. It's a totally different lifestyle where you could be able to slow down a little bit.

Historically, that's something that changed for Native Hawaiians just in the last 50 years.

In even less time. When I was a kid we still had *hukilaus* on Kauai. These were gatherings where the men would go out and lay nets in the bay, and then later all the people, the men, women and children, would gather up the nets. They'd be filled with fish. And everyone who was there was able to take some fish. There are traditional songs about hukilaus, and they were an important part of Hawaiian culture. I was lucky as a kid to live in a place where they still happened.

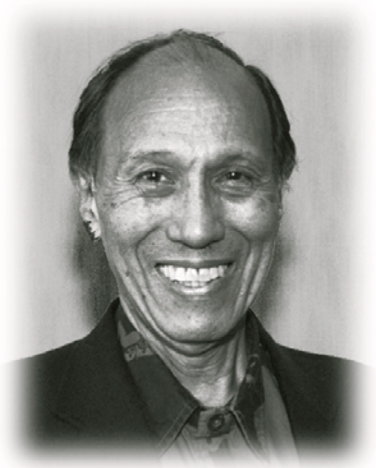
Now, you don't have that even in the rural areas. In those days, when my grandpa would come and borrow our truck, one of the neighbors would notice and call up and say, "Oh somebody took your truck." People don't do this now. Everything's a lot faster. It's happened even in the last 25 years.

Native Hawaiians are a people who not long ago had great environmental richness available to them, and now they can't get to it.

That's true. If you ask any of the politicians, they would say the beaches are free and open to everybody. But if you go to Waikiki, you can't fish there because it's so crowded. You can barely surf. You can't find parking. So you have to go farther and farther out. The people who grew up in Hawai'i grew up on uncrowded beaches. The idea of going to beaches with throngs of other people is not their idea of going to the beach. On the weekends you see Hawaiian families on the country beaches. You rarely see lots of Hawaiian families on Waikiki.

Proud Kānaka Maoli

KEKUNI BLAISDELL



__KEKUNI BLAISDELL, MD,__ was born in Honolulu, Hawai'i. He received his medical degree and did his residency and fellowship in hematology at the University of Chicago. He is currently a professor of medicine at the John A. Burns School of Medicine, University of Hawai'i, Mānoa, where he has been since the founding of the medical school in 1966.

Since 1980, he has been committed to relieving the grim health plight of the Kānaka Maoli people and supporting their political independence. He is the author and editor of several publications on Kānaka Maoli health. He received the Asian and Pacific Islander American Health Forum Lifetime Achievement Award in 1997, the University of Chicago Alumni Community Service Award in 2000 and the Kiakahi 'Ahalui O Nā Kauka Award in 2002.

He has two kamali'i *(children), four* mo'opuna *(grandchildren) and has mentored dozens of students who have become physicians in all specialties, researchers and teachers across the Pacific and beyond.*

Who has inspired your work?

My initial inspiration for a career in medicine and my self-identity as a *Kānaka Maoli* (Hawaiian) was the same person, Donald Kilolani Mitchell. He was a *haole*—a foreigner, a white man—my science teacher from 1937 to 1942 when I was a student at the Kamehameha School for Boys. This private Christian military/vocational boarding school in Honolulu was founded in 1887 to Americanize native island youth. The official policy of the school during my time there was to train us to be blue-collar workers for the haole oligarchy's dominant sugar and pineapple plantation industry.

In 1940, during my junior year at Kamehameha when I was working as a part-time apprentice electrician at the Hawaiian Pineapple Company, I was asked by Kilolani if I had ever thought of becoming a physician. I said "no," because such a profession was unthinkable to me or my *ʻohana* (family) at that time. Then came December 7, 1941, Japan's bombing of Pearl Harbor and the United States' entry into World War II. With Kilolani's encouragement, the support of my working mother and *hānai* (step-) father, I started on the long road to become a doctor. After graduation, in June 1942, I boarded a U.S. troop ship to California. There, at the University of Redlands, I acquired a BA in pre-medicine. In October 1944, I gained admission to the University of Chicago School of Medicine and received an MD degree in December 1947.

From 1950 to 1954, as a U.S. Army medical officer in the Korean War, in Japan and on Taiwan, I was uncomfortable with my privileged position in these foreign lands, and inspired by these Asian peoples' struggle against war and western imperialism. I returned to the University of Chicago in 1955 to complete medical residency training. Inspired by Professors Leon Jacobson and Ernest Beutler, who had created a renowned research section in blood disorders at Chicago, I became a hematology fellow.

My experiences with the people in those two Japanese cities sharpened my awareness of the horrors of militarism, the injustices of foreign domination.

With favorable recommendations from Chicago, I served as chief of hematology at the U.S. Atomic Bomb Casualty Commission in Hiroshima and Nagasaki from 1957 to 1959. My research with the atomic bomb survivors focused on anemias, leukopenia and myelodysplasia. My experiences with the people in those two Japanese cities sharpened my awareness of the horrors of militarism, the injustices of foreign domination and the commitment of the post-war Japanese people to peace.

In 1965, after I'd returned to Chicago, pharmacologist Windsor Cutting, founding dean of the new medical school at the University of Hawai'i, asked me to become the first professor and chair of the department of medicine in Honolulu. I was inspired by Dean Cutting's vision to create a biomedical research, teaching and clinical center for the Pacific's colonized, multi-ethnic peoples.

Upon resettling in my homeland of Hawai'i after 24 years abroad, I became immersed in Kānaka Maoli cultural activities. I came to know personally Mary Kawena Pukui, a distinguished Kānaka Maoli expert at the Bishop Museum in our traditional language, history, music, poetry and practices. I had previously known her only distantly when I was a student under the tutelage of Kilolani Mitchell.

In the 1970s, I learned that Kawena was *hoahānau* (cousin) to my *tutu hānai* (step-grandmother) Rose Mapunawailokelani Ke'ai Kruse. I sought Kawena's wisdom when I was on the Hui Hānai committee publishing her two Nānā I Ke Kumu volumes and when I was a member of the University of Hawai'i Committee on the Preservation and Study of Hawaiian Language, Art and Culture. Later, in the 1980s, I was drawn to Charles Lu'ukia Kenn, noted Kānaka historian, poet, translator and *'olohe lua* (martial arts instructor). He taught me traditions and nuances in our Kānaka language. Many of these subtleties were related to early U.S. missionary influences when these foreign zealots first recorded our language and translated their Bible into our ancestral tongue.

In 1983, I first became fully aware of the severe health plight of our Kānaka Maoli people.

In 1983, I first became fully aware of the severe health plight of our Kānaka Maoli people when I was asked by the State of Hawai'i's newly created Office of Hawaiian Affairs to draft the Health Section of the U.S. Congress Native Hawaiians Study Commission Report. Through that experience, I also came to know Kānaka Maoli traditional healer and *mahi'ai* (planter) Harry Kunihi Mitchell. "Uncle Harry," as he was known, had started to organize his fellow Kānaka health practitioners. He had also become a *kupuna* (elder) to young Kānaka committed to halting the U.S. military practice-bombing of our sacred island of Kahoʻolawe. Further, he had guided Kānaka Maoli students in the restoration of *lo'i kalo* (taro gardens) on the University of Hawai'i Mānoa campus in Honolulu. In part because of Uncle Harry's influence in the 1980s, I became involved in three initiatives in the burgeoning Kānaka Maoli movement.

First was the initial Kānaka Maoli Sovereignty Conference in 1984 at the Kamehameha Schools. The gathering was committed to reviving our native culture, reclaiming our stolen lands and restoring our Kānaka Maoli nation, which had been invaded and officially colonized by the United States from 1893 to 1898. The three conference organizers who inspired and invited me to join them were artist-poet-musician ʻImaikalani Kalāhele, land-struggle organizer Kihei Soli Niheu, and fisherman-land-evictee and then video-producer Puhipau. All continue to be champions in the Kānaka Independence Movement.

Second was the 1985 *E Ola Mau* (Native Hawaiian Health) Report and the 1986 founding of E Ola Mau, the first organization of Kānaka Maoli health professionals in modern times devoted to meeting the grave health needs of our Kānaka Maoli people. E Ola Mau provided Kānaka input in the drafting, hearings and passage of the first U.S. Congress Native Hawaiian Health Care Act in 1989. This legislation authorized the creation of five islandwide Native Hawaiian Health Care Systems and Papa Ola Lokahi (POL), a coordinating policy and research body.

Third was the 1986 Ka'u Report by a small nucleus of Kānaka Maoli on the University of Hawai'i faculty. The report became the blueprint for the University of Hawai'i at Mānoa Center for Hawaiian Studies, on the site of Uncle Harry Mitchell's lo'i kalo.

What lessons do you have to share with others?

Haole Kilolani Mitchell, Kānaka Mary Kawena Pukui, Kānaka Charles Kenn and Kānaka Uncle Harry Mitchell urged us Kānaka by example and precept to live the ways of our Kānaka ancestors and apply these traditions to relieve the distress of our people and homeland. But theirs were lonely voices in the 1930s that continued into the 1980s. To heed the call, we had to learn from the declining number of aging kupuna. We had to research and teach ourselves because the knowledge, skills and attitudes of old were banned, ignored or unknown to the U.S. colonial schools and communications media.

All in our cosmos are living, conscious and communicating ‘ohana.

From our ancient chants, we learned that we and all in our cosmos, are born in orderly fashion from the mating of Wākea our skyfather with Papa our earthmother. Thus, all in our cosmos are living, conscious and communicating ‘ohana. We Kānaka come from our sacred environment. This *‘āina* (land, environment) is our life. “Āina” means that which feeds. But our lands, resources and government have been taken from us. Our minds have been colonized by the dominant western worldview of individualism, materialism, exploitation, militarism and racism. Caught in cultural conflict, too many of us Kānaka despair and become self-destructive, with the resulting worst health, social, economic and educational indicators of all ethnicities in our homeland.

In 1987, a U.S. Congress Technical Report projected that by the year 2044, *piha* (full-blood) Kānaka Maoli would “virtually disappear.” We would be officially extinct as a distinct people. This is genocide—an international crime. However, we newly organized Kānaka refuse to accept this prediction and are determined to refute it. Our solution is to *ho’ohui* (reconnect) with our ancestors, *mālama* (care) for our ailing people and ‘āina as ‘ohana, *kū‘e* (shun) harmful foreign ways and *halihali* (transmit) our proud and adapted ancestral legacy to ourselves and *mamo* (descendents) as a revived, thriving people and nation.

Do you think the people who took the land understood these issues when they took it?

Yes and no. Late eighteenth and nineteenth century American merchants, missionaries and militarists came to our homeland, not to live as our ancestors did (i.e., sharing and caring) but to impose their assumed "superior" western "civilized" ways on us. 1n 1790, U.S. merchant seaman Simon Metcalf fired on and massacred about 100 of our Kānaka ancestors on the shores of Maui when one of his skiffs disappeared. Hiram Bingham, first American missionary from Boston in 1820, called our ancestors "destitute, degraded, barbaric, chattering, naked savages." Bingham pledged to save us from our "barbarism." Our early monarchs felt compelled to rely on the first U.S. missionaries to communicate with other foreigners, such as merchants and militarists. The New England Calvinists drafted the first Hawaiian Kingdom Constitution in 1840, established a compulsory western school system and initiated the Māhele in 1848.

American merchants, missionaries and militarists came to our homeland to impose their assumed "superior" western "civilized" ways on us.

The Māhele privatized all lands. The result was that less than 30% of our common people were awarded less than 1% of the lands. Within a generation, the missionaries, other white foreigners and their descendants controlled most of the lands of our chiefs, our King and our government. The final blow was the 1893 U.S. armed invasion and 1898 U.S. military occupation of our homeland. By these and subsequent actions, the United States has shown that it has never understood that we Kānaka continue to be part of our sacred, timeless environment, and that we are determined to restore our living nation among the world's family of nations.

Traditionally, we Kānaka welcomed foreigners. When they have shared their ways with ours in supporting themselves and our nation, we have *hānai* (adopted) them as our own ʻohana. Thus, we island natives, since initial foreign contact, have acquired western and eastern lifestyles in order to survive in an increasingly globalized world. However, although initially welcomed as our guest, the United States continues to be an aggressive economic occupier of our homeland.

What have your experiences in life allowed you to accomplish?

Fortunately, I went to medical school at the University of Chicago, a stimulating milieu where the pursuit of truth through the scientific method was honored. Racial and ethnic barriers had just begun to be pierced on the campus and in the segregated city when I arrived there in 1944. The war and U.S. military had begun to liberate Blacks.

The university was liberal toward non-whites. I was accepted by most and usually considered to be Asian and, occasionally, Hispanic. But I regularly self-identified then as "Hawaiian, a Pacific Islander." In response, I was usually greeted with a smile, as if I were exotic. I was fortunate to have faculty members who extended to me special respect and support. I am grateful that the university arranged for me to be an Osler intern at the Johns Hopkins Hospital in Baltimore in 1948/1949. I may have been the first "Asian" accepted at that southern institution. Certainly, I was the first Kānaka.

I was blessed with mentors and figures in positions of authority and responsibility who opened doors for me.

I was blessed with mentors and figures in positions of authority and responsibility who opened doors for me. Otherwise, I would not have been selected to return to the Islands in 1966 to be a professor and chair of a new department. Because of these personal experiences, I can now look back and recount some changes for the better in which I was a part.

Beginning in the 1960s, I was among the few Kānaka with an MD degree, and perhaps the only Kānaka with an academic teaching, research and administrative position in Hawaiʻi. I also sought to learn about each Kānaka community on all of our inhabited islands. Thus, besides participating in the medical education of hundreds of Island MDs since 1967, I became an advocate for Kānaka Maoli health. Through this vantage and the resulting relationships, I became part of the larger Kānaka Maoli Movement for *hoʻoulu lāhui* (restoring our Kānaka nation).

What is it you do to provide mentorship to other people?

I'm a teacher. I teach others to become doctors. I find this invigorating. I am privileged to do something that I enjoy. I've also had the opportunity to be more effective in clinical education as the chair of medicine at our new medical school. My special prides are my students. They accost me at meetings like my grown-up children. Some have children or parents who have been my students. Many have far exceeded me.

I am now involved in recruiting Kānaka Maoli students to our medical school and encouraging Kānaka medical students and physicians to pursue academic careers. Currently, we Kānaka Maoli comprise 20% of the overall population in our Islands. On the University of Hawai'i Mānoa campus, only 7% of the students are Kānaka Maoli, up from 2% when we started in 1966. For our medical school at present, we have difficulty selecting 10% Kānaka each year for the first-year class who meet the rigid modern western standards for admission.

When we began in 1966, I was the only Kānaka full-time medical faculty member. Now we are six. In the state of Hawai'i, we have doubled the number of Kānaka licensed physicians, but we Kānaka MDs still comprise only 4% of the total. We also need a broad corps of health professionals at all levels to meet the challenging health needs of our ailing Kānaka people, especially in rural communities.

This is why Papa Ola Lokahi and the islandwide health systems are so gratifying. POL is our Kānaka overall health coordinating body that oversees five Native Hawaiian Health Care Systems that attempt to reach our 240,000 Kānaka on our seven inhabited islands of Ka Pae'āina, our archipelago. POL has recently created a research program that recruits promising Kānaka Maoli students. We engage these novices in research fashioned in and by our communities. We help all concerned design and conduct each study. Our Institutional Review Board (IRB) community members must approve all research projects. Thus, these programs come from the communities and engage and serve our communities. They are not imposed by the university.

Our greatest problem is resources. We are dependent on the colonial government. *No laila* (therefore), we need to liberate ourselves from this wardship status. To do this, we need to regain our stolen lands. Thus, land struggles continue on every island.

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What are the most important issues related to disparity facing the Kānaka Maoli?

The first is clear and strong self-identity as Kānaka Maoli. This I had to learn, and it took time, personal experiences in our colonized homeland and special relationships abroad. When it became clear who I am in a neo-colonized globalized world of haves and have-nots, where I had come from, why our Kānaka Maoli people are still at the bottom, and where I need to go, I felt not only liberated, but energized. Listening to, talking to and being guided by our ancestors within and about me became not merely "belief" but a way of life.

I am not an American. I am not a Native Hawaiian. Or part-Hawaiian. Or indigenous to the United States. Those are all colonial terms

This is why the term *Kānaka Maoli* is so important. "Kānaka" means human being. "Maoli" is true, real, genuine, coming from the land, being part of the land and returning to the land. It is a metaphor. A battle cry. It means that I am not an American. I am not a Native Hawaiian. Or part-Hawaiian. Or indigenous to the United States. Those are all colonial terms with colonial definitions that keep us subordinated, compliant and subservient wards of the United States, the Great White Father. Therefore, as such, we are not fully alive, wholesome, thriving, but are made to feel inferior. No matter how hard we try, we can never make it because this is a white man's world.

Now I feel free and equal in spite of statistical health, social, economic and political disparities. I am no longer ashamed. When I attended the Kamehameha Schools as a boy, I was ashamed of my Kānaka name, Kekuni. I found it strange. In our yearbook for 1942, I identified myself as "Dick Blaisdell," two haole names.

When did you become Kekuni again?

When I left the islands for America I learned and confirmed that I could never be a white man. When I was cold and lonely in Chicago, I would sing to myself haunting Kānaka melodies, such as "Ku'u Leialoha." I would recall my name Kekuni. It began to sound less strange. I learned that it was a family name from my Keali'ikipi ancestors on the island of Maui. "Keali'ikipi" means "rebel chief," which seemed appropriate. Later, in the 1970s, my search led me to "kuni" an ancient fire ceremony to divine reasons for misfortune such as illness by the *kahuna kuni* (healer priest). I surmised that one of my Keali'ikipi ancestors had been Kekuni, a fire-ceremony priest.

When I came to know more Blacks, Hispanics, Asians and other Pacific Islanders in my travels, we found that we had similar experiences, and disparities that were different from the dominant whites. As fellow oppressed peoples, we also learned of common cultural experiences.

Strong and clear identity as Kekuni does not come easily. Appointment to a position of influence may be black-balled by the colonial establishment, which does not welcome a trouble maker. Such slights come with being in the struggle. They are countered almost daily by a cheery "Kekuni" or "Kānaka" greeting by a stranger on the street.

Can you talk more about some of the specific health problems affecting Kānaka Maoli—say, diabetes or early mortality?

Since U.S. colonial official data were first collected in the 1900s, we Kānaka Maoli have had the highest mortality and morbidity rates and the shortest life expectancy. Disease rates remain highest for *piha* (full-blood) Kānaka, intermediate for *hapa* (mixed) Kānaka, and lowest for non-Kānaka. In the 2000s, we Kānaka top the leading causes of death—heart disease, cancer, stroke, diabetes, injuries and infections. Mortality and prevalence rates for diabetes are rising for Kānaka. We also have the highest figures for most behavioral risk factors, such as obesity, tobacco use, alcohol consumption, hypertension and not wearing safety belts.

We consider the main underlying, syndemic (interacting) determinants of this dreary profile to be (1) historically, the 95% Kānaka depopulation and persistent Kānaka minority status in our homeland; (2) continuing U.S. colonial exploitation and Kānaka landlessness in our homeland; (3) western versus Kānaka cultural conflict; (4) too eager Kānaka adoption of harmful foreign ways, such as tobacco and alcohol use, packaged fast-foods, toxic drugs, sedentary lifestyles, stress, violence, crime, despair and self-destruction; and (5) institutional racism. As we Kānaka Maoli brood, self-destruction becomes an ʻohana pattern and then transgenerational.

Identifying with pride as Kānaka Maoli is essential for our healing.

Identifying with pride as Kānaka Maoli is essential for our healing. We need to live so that we are related to all in our sacred environment as ʻohana, extended family. Our oldest and longest chant, "He Kumulipo," opens with the fiery earth turning against the changing sky. This refers to Papa, our earthmother, mating with Wākea, our skyfather. Out of this mating of complementary opposites, is derived everything in our cosmos, in orderly progression, from the simplest form of life, such as the coral bud, to the most complex—*kānaka* (human). This ancient chant is thought to have been composed in the early 1700s, over a century before Darwin and Wallace and the concept of biological evolution.

One of the earliest products of conception told of in "He Kumulipo" was *he meaʻaluʻalu*, a deformity. When planted, this deformity sprouted as the first taro (*kalo*) plant. The next product of Wākea and Papa mating was Kānaka , the first man, named Hāloa. We Kānaka are descendants of Hāloa. Our *hiapo* (eldest sibling) is the taro plant. Within the ʻohana, the hiapo cares for the younger siblings. However, the hiapo taro plant cannot feed the younger siblings Kānaka without land and water. *No laila* (therefore) we Kānaka have the responsibility to regain our lands so that our hiapo kalo can again *mālama* (care for) us.

From *Hoʻokē ʻAi* (Molokaʻi Diet Study) in 1987, conducted by Kānaka Dr. Emmett Noa Aluli and Oregon haole Dr. William Connor, we learned that our traditional native foods are measurably superior to popular American "junk foods." Ten Kānaka Maoli on the island of Molokaʻi with high blood lipid levels—cholesterol and triglycerides—participated in this eight-week metabolic research project. During the first week, they consumed their usual western high-fat, high-salt diet, while measurements were made of their body weight, arterial pressure, skin thickness and blood lipids. In the next four weeks, the participants consumed only traditional

Kānaka foods, such as taro, breadfruit, banana, sweet potato, yam, berries, fish and fowl, but without change in the total number of daily calories.

With Kānaka foods, blood lipid values and arterial pressure declined while body weight remained stable. When the Kānaka participants returned to their previous western diet for three weeks, their blood lipids climbed. The participants then complained of the greasy, salty food, their sluggish bowel movements and "less energy." Here was the first demonstration that a pre-western Kānaka diet could reverse harmful blood lipid cardiovascular risk indicators in Kānaka. Since 1987, "barefoot" Dr. Aluli has continued to conduct and publish notable health care research with distinction as a University of Hawai'i medical graduate.

Another famed Hawai'i medical alumnus is Dr. Terry Shintani. Since 1990, he has promoted the *Wai'anae ad libitum* Hawaiian Diet. His data demonstrate that body weight, high blood pressure and diabetes mellitus can be controlled with a less-restricted, high-complex-carbohydrate, low-fat, low-salt, high-fiber diet of traditional Kānaka and Asian foods.

A next step has been Herbert Hoe's *'Ai Pono* program. "'Ai" means to eat. "Pono" means correct, right, just. In this scheme, people in rural communities grow their own food. At a local church or school, chef Herbert Hoe guides the participants in preparing meals with tasty elegance. They do this as extended 'ohana, sharing and caring, with cultural activities, including song and dance.

Our Kānaka basic plant foods, brought by our ancestors via canoe across *Oceania* (Pacific) in ancient times, are *kinolau* (forms) of our gods. Thus, taro is our god Kāne, *ulu* (breadfruit) is god *Kū, 'uala* (sweet potato) is Lono and *mai'a* (banana) is Kanaloa. When we eat these foods, we eat our gods. We are incorporate their great godly *mana* (special power) into us. And we become godly. Thus, eating, to us Kānaka, is a religious ceremony.

Do you have any special advice for clinicians?

I tell my medical students that the number one rule is that the patient comes first. Thus, we listen to, respect and try to understand the patient and his or her illness from the patient's perspective. To serve as a healer is a privilege.

The number one rule is that the patient comes first.

The second rule is to bring science to the bedside. Science means controlled experimentation. Thus, diagnosis and therapy must be based on the best available evidence.

Third, "doctor" means teacher. The doctor must teach himself or herself first and continuously. Doctors continue to learn from their patients, students and colleagues as they teach.

Fourth, is to have fun. That is, enjoy doctoring. No matter how difficult, painful and exhausting it can be, somehow there is always an inner glow of humble gratification. If not, perhaps you need to look elsewhere.

Fifth, there must be a reason. Why are you and I here, at this time, in this place? Is it a matter of chance? What is our purpose? Every clinician needs to answer this life *nīnau* (question) for himself or herself.

What are your hopes, dreams and visions for the future of your people?

So much is moving so fast. It's rapidly changing world of uncertainty, contradictions, paradoxes and ironies. We should not get too involved in this stressful, seemingly endless treadmill without pausing to ask ourselves, "Where is it leading?" For us Kānaka Maoli, we must never lose our roots, never forget where we come from and to whom we remain connected.

Our *'ekolu piko*, three anatomic body centers, are daily reminders. The first is *piko waena*, our navel. It represents each Kānaka's attachment to his mother in intra-uterine life. Thus, it reminds us of our contemporary world from our personal birth to our death on this planet This piko covers the *naʻau* (gut), our seat of learning, knowledge and feeling. The second is *piko poʻo, manawa,* the anterior fontanel in the newborn infant. It is the opening that connects each person's *ʻuhane* (spirit) or *wailua* (soul) with his ancestors since the beginning of timeless time. This piko remains active and connected only when each person talks to, listens to and is guided by his ancestors. The third is *piko maʻi,* between the legs, the genitalia. This body part connects each person to his *mamo* (descendents) forever into the future. *Akā* (however), we Kānaka do not think linearly. Our mamo after us connect us with our ancestors before us in a timeless full circle. We communicate with them and they communicate with us, forever, living and conscious. With these timeless concepts, how can we feel insecure, despair and become self-destructive?

This brings us to another concept: pono—just, fit, appropriate, balance, harmony of complementary opposites—such as male and female, day and night, hot and cold, good and evil, health and illness, life and death. We cannot escape them. They are reality. So life is both struggle and joy.

Anything you want to add?

I want to express how grateful we Kānaka Maoli people and nation are to Blacks, American Indians, Hispanics, Asians and other indigenous peoples and nations of the world who have inspired us. They have given us hope and courage to rediscover our true identity. To no longer be ashamed. To heal ourselves. We join these others in our common struggle, not merely to survive, but to thrive in our homeland. With growing self-confidence, we also need to earn the respect and support of the non-indigenous world in creating a new family of globalized nations in which both the oppressed and the oppressors are liberated in honoring our sacred, life-giving cosmos.

> *We join these others in our common struggle, not merely to survive, but to thrive in our homeland.*

Building the Capacity for Care

Eliuel K. Pretrick

Eliuel K. Pretrick, MD, MPH, *is secretary of the Department of Health, Education and Social Affairs of the Federated States of Micronesia. He has also served as Secretary of Health and Human Services. He is a member of the Pacific Island Health Officers Association, the Pacific Basin Medical Association and the Micronesia Medical Council, and is president of the FSM Sport Council and National Olympic Committee. He obtaind his medical degree from the Fiji School of Medicine, University of the South Pacific, Suva, Fiji Islands.*

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Who has inspired your work?

It's the need of the people here. It's the government that provides the services. That's what makes us try to provide the appropriate services to the people in the Federated States of Micronesia (FSM).

My response is based on my experiences here. I was a teenager immediately after World War II. There was a very high prevalence of yaws among the all the people in this part of the world. So when the U.S. military came in they set up a hospital. They were working hard on treating yaws because it was already an epidemic.

Yaws is a tropical disease. The organism that causes yaws is similar to the organism that causes syphilis; so people who contracted yaws developed an immunity to syphilis. In our first 20 to 30 years under the U.S. administration we didn't have the problem of syphilis because of the immunity developed through yaws. But now we are beginning to have cases of syphilis being reported. This is because by the late 1950s yaws was eradicated; it was very sensitive to penicillin.

When the U.S. military came in, there was not one single Micronesian who really had knowledge of nursing or even first aid.

I was admitted to the hospital for about 8 months for treatment of yaws. When the U.S. military came in, there was not one single Micronesian who really had knowledge of nursing or even first aid. As a patient, I became very interested in trying to become a health worker.

At that time I couldn't speak English. Our language is different. Under the Japanese we learned to speak Japanese but not English. When the U.S. military came in there was still no education system established but I watched the medical workers helping people and became very interested. That was my first motivation to become a health worker. Eventually, I was able to become a physician.

What was that experience like for you—being trained as a physician?

First of all, looking at our situation here, there are no health workers. Those of us who became interested had a hard time going to medical school. But we felt there was a need so we worked very hard trying to learn from the military people.

We finally got into the more formal education. At the same time we were trying to learn English. The military people, knowing that we didn't speak good English, tried to help us by showing us practical aspects of caring for people.

When I finally learned something about English, I was accepted into a medical officer training program. This program is still going on—the Fiji School of Medicine. That's where I finally was admitted and went to medical school for 5 years. I struggled because my educational background was very low, but it was hard work that made me successful in my effort to become a medical officer and physician.

What have you been able to accomplish because of the people you've known, the things that have happened to you, the hard work you've put in?

Through hard work and the help of other people to see that I got what I needed, I finally made it as a medical officer and physician. I then returned to my home island where there was a high prevalence of communicable diseases such as tuberculosis, leprosy, intestinal parasites, filariasis and skin conditions.

These were preventable conditions but people were not educated about prevention. They would consider taking care of their bodies once they were suffering. Otherwise, prevention was not something in the minds of the people. There were few doctors and most of our time was spent curing the high prevalence of disease.

In order to teach the people about prevention, we tried to identify the diseases that were affecting them. People came to understand that there are lots of serious diseases. Then we tried to teach them that these diseases don't just come into the body. People needed to change their lifestyles in order to prevent the organisms from getting into their bodies. It took time for them to begin to understand. The people who really suffered from the diseases could understand when we talked to them, but those people who were healthy and weren't suffering didn't understand very well. But we continued to emphasize education.

I started from scratch. But today I can appreciate that there are more physicians, more nurses and better-equipped health facilities to accommodate the care of the patients. The general public is beginning to learn more about the importance of good hygiene, the importance of healthful food; and they know now much more than years ago about the prevention of diseases. They take part in it. That is a big payoff that we have. People are now beginning to participate.

I started from scratch. But today I can appreciate that there are more physicians, more nurses and better-equipped health facilities to accommodate the care of the patients.

In terms of Pacific Islanders generally and the people of Micronesia especially, what do you think are the most important issues related to health disparities?

Today we are still trying to improve our facilities, capacity building and developmental power. They are still our primary emphases. We are now strongly emphasizing our primary health care, where people can plan and take part in activities to prevent diseases in their communities. We encourage people to take part in the payment of health care because our government is limited in funding. We provide our health care here almost like social services, where government is the main source of funding.

We still have a long way to go to bring our standard of health care closer to what is provided in any small community in the United States. Our facilities haven't reached that level yet. We're limited with certain procedures and specialized services. The health care our people receive is not in any way equivalent to what is provided to our citizens who are living in the United States.

You are active in the Pacific Island Health Officers Association. Can you say something about your work with them and what they accomplish?

The Pacific Island Health Officers Association (PIHOA) was established in 1986. The primary goal was for us to become the speakers for health issues in the region.

We do not try to handle each jurisdiction—or each territory's activities—but we are involved in the entire region.

We look at health programs on a regional level and try to share information about what needs to be done. We are like neighbors here so we have to share this information—especially of epidemics and diseases—to notify other islands that there is a problem in one area so that action can be taken to prevent its spread. We also look at the areas that need to be improved and try to seek financial and/or technical assistance for them.

We look at health programs on a regional level and try to share information about what needs to be done.

One of our major emphases is the epidemiology of diseases. For instance, communicable disease was a big problem some years back. Today we still have some communicable diseases but they are no longer the high-mortality diseases. Now a lot of noncommunicable diseases are emerging. This goes along with the change in lifestyle of the people. Diabetes, hypertension, cardiovascular disease, stroke—all these are getting to be on top of the list of our health problems. So PIHOA tries to look at these and monitor how best we can control them.

What happens when people from the islands are receiving health care in the United States, either on the mainland or in Hawai'i? Are there any recommendations you have for those who are providing care?

This is one of our weaknesses. We do not really come face-to-face with our people who travel out of the FSM. We advise people that if they are planning to travel from the FSM into the United States they must get some kind of health insurance should they become very sick. So our young people who are traveling to the United States have been informed that health insurance is very important. They usually find the health services in the United States much more comfortable and attractive than what they were receiving in the islands. These are people who travel to the United States looking for jobs.

Also, there are a few people whom we refer for specialized medical care. These are usually handled by the government. Because medical costs in the United States are so high, we find it very difficult to put up the money when we receive our bills for medical referrals. This is one problem we encounter.

Is there still a need to encourage young people in FSM to enter the health profession?

We continue to emphasize the development of new health care professionals. This is vital. We have a few high school and community college programs to encourage young people to take up subjects that could lead them into medical roles—nurses, physicians, lab workers.

We continue to emphasize the development of new health care professionals.

This type of capacity is critical here because our population is very small—and dispersed in an ocean area of about 1.8 million square miles. Sixty islands are inhabited with populations ranging from 150 or 200 people on one island up to 30,000 on another. We have the problems of transportation and communication. The outer island people still need medical care. Those who live in the central areas where our hospitals are located are more fortunate. They have access to better care than the outer island people, who may have health assistants with only 6 months of practical experience.

My job as secretary of health is to help maintain health care services to people on the islands that are scattered out in the FSM, especially in the area of primary care.

What is your vision or dream of what the future might hold?

I would really like to make sure that people receive adequate health care when they become sick. I envision that people will learn more about prevention and health promotion so they can take part in the care of themselves and their children. I would like to see the government continue to provide necessary and basic services such as immunizations, to make sure dispensaries are provided with drugs and hospitals are equipped. And then I would continue to provide education to the health care workers to improve their skills. These are the areas we are trying to improve.

> *I envision that people will learn more about prevention and health promotion so they can take part in the care of themselves and their children.*

Health care alone cannot improve the well-being of the population. It takes economic development. It takes good education. It takes improvement of our living standard. I think that all these together will help promote the better health of the people of the FSM.

Anything else you would like to say?

We Pacific Island people who are remaining on the islands try our best to utilize whatever assistance can come to us—whatever financial resources are available to support our health services. The Pacific Island leaders need to work together with the United States to see how we can best improve the type of care available to Pacific Island people who are living in the United States.

Bridging the Barriers

MERINA SAPOLU

__MERINA SAPOLU__ was raised in Samoa, where she was a teacher for 11 years. She moved to Hawai'i in 1974, and began volunteering at the Kokua Kalihi Valley Clinic in Honolulu. She joined the clinic as a staff member in 1975, doing outreach in the Samoan community, serving as a medical translator and acting as a liaison between Samoan patients and medical and government agencies. In over 25 years at Kokua Kalihi Valley Clinic, she has coordinated both the medical and dental programs, provided community education on HIV and other STD, developed programs to promote breast and cervical cancer screenings, and acted as a general advocate for reproductive and women's health issues.

She has been active in Fetuao, an organization that promotes HIV prevention in the Samoan community, and has helped represent Kokua Kalihi Valley Clinic in the SisterSong Women of Color Reproductive Health Collective, which addresses reproductive health and sexual rights. With all of this experience, she remains, at heart, an outreach worker and health educator, and is grateful to the Kokua Kalihi Valley Clinic for the opportunities it has offered her to represent Pacific Islanders in a variety of health care endeavors.

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Who has inspired your work?

I was a teacher originally and I loved teaching. That's what I had always wanted. And then I moved to Hawai'i with my family. When we first came my husband had some health problems and I did not know where to turn. It was very serious and I wondered if we should move back to Samoa because of it. The only person that I knew of, because I didn't have any family over here, was our landlord. So I called our landlord and he came to see me and helped me get the help that I needed. I was fortunate that I could speak English and I was able to call someone for help.

Then I started volunteering for the agency where my landlord was the executive director. I hadn't known anything about what work he did, but I found out that he was the executive director for a new comprehensive family services agency. When I started volunteering, I found that there were many people in the community who were not able to get any help at all—whether it's health, welfare or other needs—because they were not able to communicate. The agency where I was working was trying to help out the people in the community.

This was the start of what is now known as Kokua Kalihi Valley Clinic. It's a place that helps people in the community who wouldn't go elsewhere—whether it's for health issues or anything to do with welfare or with other government agencies, even with the schools. I thought this was great work, and that I could help speak for Samoan people who weren't able to help themselves because of the language barrier, or because of feeling afraid to seek treatment.

Joris Watland is the executive director who introduced me to this organization. My own feeling of helplessness when I did not know where to turn or whom to call for help made me want to stay and do the work that I'm doing now. I wanted to help as many as I could by communicating their needs. Even today, Joris Watland and the people who really need help inspire me in my work.

My own feeling of helplessness when I did not know where to turn or whom to call for help made me want to stay and do the work that I'm doing now.

I think also those who have inspired me in my work include my parents—the way I grew up at home, the way we were treated. Usually my father would say, "Do not think that you are above anybody. Everybody is equal in the eyes of God and we should treat the next person the way we would like to be treated."

What are some of the lessons you've learned from others?

I've learned that people could be treated badly by some professionals. That doesn't mean by all professionals and it's not because they want to treat them badly. It's because: (1) there could be a language barrier; (2) the cultures are so different and so diverse among the people who are coming in that the providers do not know how to treat them; and (3) people could be turned away by a look, by the way someone has spoken to them, or just by seeing that someone doesn't care.

The thing that I tell the people is that it's not that professionals don't care, it's that they don't understand the problems that the people are coming in with. That's because we sometimes speak with an accent or we say things differently from the way they know. Reaching some of these patients is so easy. Just a smile will do so many things. I have found that some of the providers tried to learn to say "hi" in the patient's language. That's a big thing with patients—to know the provider across from them is taking the time to try to learn just one word from their language. It says, "That person cares."

Reaching some of these patients is so easy. Just a smile will do so many things.

I've also seen women who would not go in at all because the providers are all male. That's another barrier. Sometimes there is stereotyping going on with some of the ethnic groups—"Oh, they are big, they are always big, they always eat so much, they're heavy, they'll break the scales"—things like that, things that were meant just jokingly. But it hurt the people who would understand some of what had been said.

We had this provider who would hold onto the hands of the patients and look directly in their eyes and speak in a very soft way. Sometimes that was all that was needed for them to come away feeling happy, knowing there was somebody who cared about them.

Treating somebody the way that you would like to be treated—that was something that I have learned for myself too. If I go in to see a patient with my own ideas about things and that's not what he or she would like, I'll always step back and say, "Is this the way I would like someone to speak to me?" Then I change my tone of voice.

What are you proud of being able to accomplish?

I grew up in a large family. Sometimes it's a disadvantage, but that's what made me the person I am now. We took care of each other and were there for each other. That's how I feel about my work here. Being able to go beyond just being a professional. Being able to treat everybody who walks into this clinic as though we are from the same country or family. I would not say, "Oh, she's Filipino. I will not do anything for her." That's not how it is.

I have worked in this position in this agency for over 25 years. I'm proud to say that I'm a human being. I don't really hold up my ethnicity as a big thing. I will treat everybody the way I think I should be treated and make them feel comfortable. There are times too when people would say, "Why should you go with those people into the hospital?" But people need the presence of somebody who makes them feel comfortable, especially when facing these new procedures.

People need the presence of somebody who makes them feel comfortable, especially when facing these new procedures.

I know that I have talked about things that I would've never dreamed of talking to the public about back home—especially about sexually transmitted diseases and AIDS. I wouldn't have dreamed of being able to go on TV, go to churches and speak to people about these things. But I got over that hurdle by being well trained by Kokua Kalihi Valley, and knowing that some of our populations could be wiped out if nothing is done.

I'm proud that I was able to educate the people here in our community—whether they are Samoans, Filipinos, Laotians or Koreans—by going into the schools and doing presentations to the students and parents about some of these deadly diseases—especially in a place like this where we still have a hard time trying to get people to seek treatment. I am grateful to this organization for allowing me to move forward and to be trained in doing this—I wouldn't be able to do it if I wasn't given that opportunity—and to the ministers and community leaders who allow me into the communities to do what I was trained to do.

What do you think are the most important issues contributing to health disparities among Samoans, Hawaiians and other Pacific Islanders?

First and foremost is the language barrier. Here at our agency we're lucky to have so many people to help out. But not all of the people come to us. Some will go to other places and have a hard time because there aren't any materials written in our languages.

First and foremost is the language barrier.

Culture is one of the biggest things too. There are some places where they still follow the traditional style. All they know is the traditional way. Also, the providers can be a big cultural barrier in the way they do things—or if they are not the right gender. However, I have seen providers who are not from the ethnic group that we are from who are culturally sensitive. Sometimes the worst ones are people from our own ethnic groups. They can be part of the problem because some of them have class issues—they are up there and these people they are seeing are from down the ladder. The way they treat people is so bad, and yet they are people who can speak the language and are of the same culture. So it's hard for me to say we need exclusively people from our own culture as practitioners.

I have also seen financial barriers. People without medical insurance cannot afford to go see a doctor.

Sometimes transportation will stop them—they can't get to the clinic. Or they might be afraid of seeing western doctors. Some of these people have never seen a doctor in their lives. So it's a big step. A lot of times they will go to their traditional healers before they would ever see a doctor in the clinic or the hospital. So by the time they come in it will be so bad that they need hospitalization or end up dead. If people feel they are treated like less than they know they are, that also explains why they won't come in.

We always try to come up with things to make people see that they still need to come in for screening, even if they don't want to know about it.

Sometimes religion can play a big part. I've been to a group where we talked about breast and cervical cancer and a lot of times women will say, "If it's God's will that I die, who am I to question it?" Usually I would say, "Do not blame God for your own laziness. You think God would like you to die? That's not true. God helps those people who help themselves. So if you do not want to help yourself, you will die for sure. And that's not what God wants from you." So we try to talk them away from those beliefs. Sometimes they will listen. Most of the time they will laugh about it and they will seek help.

Another thing is the fear of the unknown. We have health educators who are going out into the community to talk to the women to get them to come in for early screening. They say, "Oh my gosh, the women say they don't want to know if they have cancer or not." So we always try to come up with things to make people see that they still need to come in for screening, even if they don't want to know about it. There are other family members who might be affected later by their actions.

The younger people say, "Oh, it's not me. I'm not going to get it. That's OK. Thank you for telling me about it but, no, I'm not going to get it. I'm too young to die." So it's that attitude.

What advice do you have for practitioners?

Show that you care. Treat the people with respect. Treat them like people. Take the time. The people here at Kokua Kalihi Valley are so lucky because the providers take the time to listen to their stories. But when they go to private practices it's not that easy. The doctors and providers are trying to make money and they don't have the luxury of listening.

Here's another thing. If there are any translations to be done, don't look at the translator at all, but speak and look at the patient. Some of these people, especially with the Pacific Islanders and many of the Asian cultures, were brought up to not look anybody in the eye. Often the doctor is being put up on a pedestal by our people, and sometimes whatever the doctor says goes. They wouldn't know how to question or how to ask for a second opinion. They'd be concerned that the doctor wouldn't let them come back if they asked questions—and that's not the case at all. I usually say if the provider doesn't understand what the client is coming in for, use a translator.

If the provider doesn't understand what the client is coming in for, use a translator.

But most of the time with doctors, the important thing is doing things in a caring way—not to be too pushy and not too cold. I've seen providers use a harsh tone with patients. The tone of voice used when talking to clients has a big impact.

We have a provider here who works in our clinic. He's not from any of the patients' ethnic groups. He's Caucasian. But the patients like him. We had this Samoan woman who had gone from one provider to the next, complaining about all of them, before seeing him. The next thing we knew she had gone into the Samoan community and spread the word about him. "If you would like to see the face of Jesus Christ, go down to Kokua Kalihi Valley. The face is there." And that's because this young man will take the time to sit down and talk like a neighbor and include the patient in what he is doing. It would be very good to include the clients in their own care, not just tell them, "Blah...blah...blah...take this medication."

Do you have the opportunity to mentor others in patient care?

Kokua Kalihi Valley Clinic is a training site for some of the university students—medical students, social work, nursing and nutrition students. I'm one of the faculty—there are four of us—helping the students. We take them into the community, or to see clients in the clinic. I also teach some women and young girls from the high schools. We are one of the sites where students come in from the colleges to do their field work.

Anything you want to say regarding how to be a good mentor?

A good mentor has a lot of patience. Mentorship means continuing what we are doing, by letting people in training know how the people in the community feel and how they should be treated—and just getting to know them. Usually by being a mentor, not just talking about it, people who are under you imitate how you do things. I would encourage other people to be mentors—especially people who are working with diverse communities.

What are your passions, visions, dreams and hopes for your people?

I'd like to see everybody having the same opportunity in getting health care—and everybody getting equal treatment. I am hoping that the people, not just the providers, would see that their health is very important and take control of their own health.

> *I'd like to see everybody having the same opportunity in getting health care—and everybody getting equal treatment.*

I was lucky that I was a teacher before. It made it easier for me. And the chance to work in this agency represents teaching in a different sense. I think what I'm doing now is as important, if not more important than being a schoolroom teacher. I'm reaching more people and different ethnic groups. I'm glad I chose being a teacher. It prepared me for what I am now.

What are your ideas for empowering women regarding reproductive health care?

Reproductive health care is one of the most difficult topics to talk about with our population. We've tried to partner with women and their families to encourage early testing. Usually they would say, "I wouldn't want to know if I had cancer, if I were ill." I would always say, "It's fine if you don't want to know about it, but think of all the other generations that will be following you that might be affected." A lot of times that would change the way they look at it.

They may say, "My friend told me it's very painful to go in for the mammogram." We try to get women who have had mammograms to come in and reassure them. We work with many ethnic groups and they will say, "There's nobody to go down with us." So I'll drive them down and be their spokesperson, because sometimes at the intake desk at the hospitals they will ask a lot of questions. Women have just turned away and left because they didn't understand the questions.

We tell the women that they have to take their health into their own hands.

We tell the women that they have to take their health into their own hands. They have to ask the doctors questions if they feel like some of the services that are due to them are not being offered. They should have the courage to say, "Isn't it time for me to have a Pap smear?" Or, "I haven't had a mammogram for many years. Shouldn't I go in?" Or, "I didn't have any clinical breast exam last year. Shouldn't I get it now?" We try to tell them, "It's your life, women, don't wait for somebody else to take care of you. Take care of yourself because you're the caregiver for your whole family."

If you could construct a prevention program for your people what would you include?

First I'd have people trained who would be able to go out into the communities—good public speakers. I'd have these people trained so that they would be well versed in the culture and comfortable about the topic.

Education should also be done in the media. Most of the ethnic groups here have either a radio or a TV. Media and outreach should work collaboratively to educate about all kinds of diseases—breast and cervical cancer, sexually transmitted disease, HIV/AIDS, hepatitis B. It's very important to have the media be part of it.

There should be written materials in native languages. I've seen English materials in trash bags. I think it's because most of the time people don't understand them. I pick the ones that are simple to understand. It should be as simple as it can be and yet the message should be there. It wouldn't hurt for more pamphlets to be in different languages.

There should be written materials in native languages.

That's why having the media as part of education is very important. Then messages will be sent in the different languages. People see somebody on TV talking about it. Health educators can't be everywhere. There are still those people who aren't coming in, so the media could take our place.

Anything you want to add?

I want to thank you for taking the time to listen to some of the people in these groups, people who are part of that group that are not coming in at all, people who are feeling they are unfairly treated, that nobody's reaching out to them. They aren't accessing health care the way it should be accessed.

Keeping the Culture & Providing Care

Faye F. Untalan

Faye F. Untalan, dsw, mph, *was born in Guam and comes from the Chamorro culture. She is currently an associate professor in the department of public health sciences and epidemiology at the John A. Burns School of Medicine, University of Hawai'i, Mānoa. She received her doctorate in social welfare and health policy from the University of California, Los Angeles. Her research interests include migration and adaptation of Pacific Islanders, child health services, adolescents in foster care, abstinence education, and incidence of cancer in children. She is the author of numerous articles on the health of Pacific-Islander children and families.*

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Who has inspired your work?

The public health nurses I worked with on the island of Guam inspired me with their ability to work, their ability to deal with the villages and the people. They showed me what the needs were and what was required to serve those needs. And I think that led to my desire to pursue professional education and become more involved in public health. I actually went into the field of public health and social work.

My mother was also always there. She gave me the confidence, the will and support to pursue my education and my professional dreams.

Throughout my professional education and experience there were many other people who inspired me—either gave me confidence or gave me the drive to pursue the field further.

One public health nurse who really inspired me was Olivia Guerrero. We called her "Bai." She was one of the early nurses on the island. After the War, the island was becoming more exposed to American education, American ways and so forth. The nurses would come to the schools to talk to us about pursuing fields in health.

After the War, the island was becoming more exposed to American education, American ways and so forth.

I was still in high school and I wanted to be a doctor, but I knew my family couldn't afford that type of education. So she brought me to work in the Department of Public Health. I saw the kind of commitment she had for the people. I was just another kid on the island but she reached out to me. She was always able to identify people with strengths or skills and give them the opportunity to contribute.

It was an interesting time. Compared to the Mainland, I think it was almost like growing up in Colonial America.

What was the health status of the people who lived on Guam at that time?

At that time people were generally healthy, but western problems were starting. That was the beginning of change in terms of diet, lifestyle, employment and economic situation. What we now see as the problems of modern times actually began then.

Part of it is that people lose their primarily agrarian lifestyle and become more dependent on processed foods. It's easier to buy canned food than it is to go out and raise crops or fish. Around the 1960s and 1970s, I was appalled at the number of people who had heart disease, stroke. I knew men who died as early as 36. Then diabetes began to be an issue—something I had never even heard of before. It started in the 1960s and 1970s and became a significant problem later on.

My grandfather had never been to a doctor and died at the age of 70 of a massive heart attack. But he lived to the age of 70 which is pretty healthy for today's generation.

What lessons do you have to share with other people?

When people are rapidly going through change, they don't have the mechanism to learn the consequences of change, or to proceed gradually.

When people are rapidly going through change, they don't have the mechanism to learn the consequences of change, or to proceed gradually. Sometimes they realize these things when it's too late. What's needed is for health providers to give anticipatory education to people who are going through these rapid change experiences. I know it's not easy to do but it's something we need to consider so people can learn how to avoid the consequences.

My own mother died as the result of emphysema. She smoked from the time she was very young and it was hard to change her lifestyle. Toward the end she would tell me if only she had known.... Maybe that is typical of people at that stage, the regrets. For some, a better understanding of the consequences of certain behaviors or situations might help.

Guam is a U.S. colony so there's a colonial type of administration there, even today. We are expected to deliver services and programs similar to what would be offered on the U.S. mainland. And that's so difficult because the infrastructure, the culture and everything else is so different. Somewhere in the higher echelon, at that level of policy making and program design, the federal government needs to be more cognizant of how programs affect people in this remote island with different cultures, needs and resources.

Can you give us an example of something that didn't work and how it could work better for people in Guam or other remote islands?

One thing is definite—resources are greater on the mainland. Now I'm expanding beyond Guam, because Guam is more developed than some of the other islands. For example, sometimes electricity is not available. Vaccines may be ruined because there is no refrigeration, there are no resources to handle the vaccines. Any vaccination program has to be made very flexible to reflect that.

Sometimes before a service can be delivered, other types of development are needed, like a delivery mechanism. How do you get the service to the people? That often is not possible. When providers get resources on those islands, there may not be opportunity to use them. If they were simply given the money, they would know how it could be used effectively. Local providers have the flexibility and expertise to design programs around local needs. I'm talking about general issues and the feelings many providers have regarding some of the federal programs.

Local providers have the flexibility and expertise to design programs around local needs.

For example, when we had a lot of HIV funding, they would send it to places where there were no cases of HIV. Yet they insisted on it. On the other hand, diarrhea and other kinds of gastrointestinal problems are endemic, but we could not use the HIV funds to address those issues. In places where the needs are pretty clear, the resources could be directed toward those needs first.

For quite a while, we were considered by the government to be one group, Asian and Pacific Islanders, rather than distinct groups. In some universities that I worked in—in fact when I worked at the University of Colorado—recruiters would not reach out to Pacific Islanders because they'd look at the statistics on Asians and say, "There's no need for assistance because their income level and educational achievement are high." That does not answer the needs for people from Guam or Samoa or any of the other Pacific Islands. These are some of the problems created when we're lumped together as one multiethnic group. That is an example of how programs and policies often don't really meet the needs of certain small isolated areas.

Sometimes when a community is small, it's very hard for public policies to meet their needs.

We are very small. If you look at the statistics, we are 386,000. In the United States, that's like one group of Hispanics in Texas. So you can see, sometimes when a community is small, it's very hard for public policies to meet their needs.

What have your life experiences allowed you to accomplish? What are you proud of?

I'm very proud of the fact that I've been able to achieve a lot of my educational goals, work with a variety of people and have opportunities to do research. Deep down, I see my work as being able to serve, to contribute and to enhance health and life of people I serve. I enjoy my work because I'm doing it around things that I believe in—and I have the opportunity to encourage others to pursue the same kinds of ideas and goals.

You've worked directly in the community as well as in university settings.

Yes. To me it's very important to be part of the community and connect that as an integral part of my life. We are very socially organized people. I make the effort to stay continuously involved.

Currently I'm looking at children with cancer from the Pacific. They often come to Hawai'i because there are no services for cancer treatment on the islands. I was at the hospital one time visiting some patients and was surprised how many kids were there from Guam. I talked to one of the oncologists and she agreed to work with me to do a study to look at that because nobody knows about this population. We wanted to gather information so that we can do something about it. Are there things we can do to improve the outcome of their condition? The quality of their lives and that of their families? That is an example of how I connect my community involvement with my academic work.

Also, I am on the Census Committee, so I try to make sure the people are actually accounted for and adequately represented. I began organizing the Pacific Island groups in California way back when we started realizing that community groups can benefit from programs and services from the state, county or federal government. We organized it to enable people to participate in their communities.

I am on the Census Committee, so I try to make sure the people are actually accounted for and adequately represented.

What are the most important issues related to health disparities concerning either the Chamorro people, or Island people in general?

The inadequacy of health care facilities on the home islands. If people are acutely ill and cannot be handled there, they have to be moved to Hawai'i, the nearest place with comprehensive care. Care under those circumstances becomes very difficult. Many times people don't even seek care because they just can't afford it.

Many times people don't even seek care because they just can't afford it.

People don't have health insurance. That's a real problem. Those with health insurance can seek care, but people without it would be denied.

Other issues are the need for community education and better programming on the islands at the prevention level. We can probably prevent a lot of health problems by giving people access to and education about early intervention. We did this in California, making women aware of Pap smears and mammography to detect early signs of cancer. Also, on the island, we need better opportunities to detect and treat conditions early on. There's a real lack of prevention and early intervention on many of the islands.

In addition to the financial barriers, is there some hesitation on the part of the people who live on remote islands to get medical care, to get involved in the mainstream western medical culture?

There are people who have some hesitancy. In many cases they will start their own cultural approaches to treat a condition, and then if that doesn't seem to be working they will seek outside care. Many of them will go back and forth. I hear sometimes that people don't have much faith in modern medicine. There's a lot of belief that illness is the will of God. I'd say that people are more accepting of illness and don't see that many conditions can be controlled and treated. This is not good, but I also think there's a little wisdom there. They are more accepting of Nature. There are sayings in the language, such as, "That's the way it's supposed to be."

What advice do you have for clinical practitioners?

Giving people recognition and respect is very important. Then people will have a sense of trust and be able to reveal their situation. It gives people a sense of confidence and a sense of empowerment.

Giving people recognition and respect is very important.

I used to take my mother to the doctor. And she would always be so compliant. She'd complain of all kinds of symptoms at home, and then when we'd get to the office she'd say she was fine. We need doctors and clinicians who take a little bit more initiative with patients on the islands. People are polite. They sense that the doctor should be able to read their condition without hearing them speak. This makes diagnosis difficult. I've heard some doctors say, "They didn't say anything." And I've said, "Most of the time they wouldn't say anything. They'd want you to take the initiative."

What sorts of things might a clinician say to bring that forth from a patient—that he or she was having painful symptoms?

I think it's most important to take time and be patient. Many times, people see practitioners as being busy and not having time. A practitioner who is patient allows the person to have a sense of comfort. Not only in the moment but also over a longer period. It helps when practitioners see the same people over time and develop trust, so people become more willing to share their conditions.

Islanders feel that reciprocity is very important and they want to reciprocate by giving you something. My mother lived in Washington State, and when I'd go there from Hawai'i to see her, she would always ask me to bring something. These gifts were really for her doctors.

Allowing people to do this is good. Many times in our western ideology we don't give professionals gifts. There is no room for this reciprocity. I think these patients feel a sense of identity with their caregiver if they are able to give something. Our western ways tell us that's unprofessional and unethical. But our providers have to understand that most island people know how far you go and what's acceptable and what's not.

What is it you do to mentor other people?

I always reach out to the kids from the islands and encourage them like my mentors did for me. I've been here at the University of Hawai'i for over 15 years. One of the things I've done is reach out to the Pacific Island Studies Department to develop programs to give the students from the islands a sense that there is something here for them. So I teach Chamorro language and culture here.

Part of my objective is to help young people from the islands appreciate their culture, their heritage, who they are—and to guide them.

Part of my objective is to help young people from the islands appreciate their culture, their heritage, who they are—and to guide them. They are far from home. I give them whatever advice I can in terms of their education and professional pursuits. I have my own group of students with whom I've worked over the years. It's hard work, but I really enjoy it. Part of my real interest in being a mentor is that people have mentored me well.

I've also worked with a lot of the other groups here. Pat Locke, with the Dakotas—she was a good friend of mine—I used to watch her work with American Indians and I really admired that. Marta Sotomajor, with the Hispanics. Esther C. Spencer, who has died, was a social worker in California, and to me was a very inspiring woman. So there are many people who have helped me become what I am.

What vision, hopes do you have for the future?

I see us losing a lot of our values that were so wonderful as we become part of the larger American society. And that's something we have very little control over because we're part of the society and we need to adjust and adapt. But the loss of the beautiful culture is sad. I don't want people to become defiant. I don't want them to lose the importance of people, the importance of sharing and the importance of caring. Perhaps we could find some way to keep the good part of a very humanistic, very caring culture, in this western culture that is very competitive and very individualistic.

This is why I involve myself with students because I see them as the future that will carry on these values. We can become not only successful as we move into the dominant society, but also maintain the valuable cultural legacy that we have. One way is to be a model to other people who will see that and carry on. I know that my time here is only for so long, and others will have to continue in perpetuity.

We can become not only successful as we move into the dominant society, but also maintain the valuable cultural legacy that we have.

Seeing the Context of Their Lives: Reaching Island People

Left to right, first row: Roslyn Reynold, Rosa Ayuyu. *Second row:* Andita Meyshine, Denitha Palemar. *Third row:* Joaquina Ulenghong, Selerina Malsol. *Fourth row:* Faye Untalan, Carmina Alik
Not pictured: Jacki Tulafono.

EIGHT HEALTH PROFESSIONALS *who work in various Pacific Island communities met in Honolulu, Hawai'i, to discuss health disparities among their populations. The group shared their experiences, the inspirations for their work, and offered suggestions for reducing disparities.*

PARTICIPANTS

Carmina Alik, BS, Marshall Islands
Rosa L. Ayuyu, Saipan, Mariana Islands
Selerina Malsol, DCHMS, Palau, FSM
Andita Meyshine, BSN, MPH, Chuuk State, FSM
Denitha Palemar, Yap, FSM
Roslyn Reynold, BSN, Kosrea, FSM
Jacki M. Tulafono, BS, Pago Pago, American Samoa
Joaquina "Kina" Ulenghong, Palau, FSM

FACILITATOR

Faye F. Untalan, DSW, MPH

Faye Untalan: We have with us today eight representatives of various Micronesian Pacific Islanders. Please introduce yourselves and tell us about your work in public health.

SELERINA MALSOL (PALAU): I'm a physician from the Republic of Palau. I did my training in the Pacific Basin with a research training program in Pohnpei and graduated in 1996. I've been working as a doctor for the past 5 or 6 years—as an OB/GYN. I've been in Palau at the clinic, as well as other public health clinics. Recently I've been getting more involved in public health. I've taken classes here in Hawai'i, and I'm also taking more of a public health perspective in the family practice in Palau.

Is there anyone who was key in terms of inspiring your interest in the field of public health?

SELERINA: Yes. An American volunteer stayed with my family a long, long time ago in Palau and later he graduated in Hawai'i as a doctor. He was director of a public health program in Palau. He told me about the program and the work he was doing, and I found it very interesting.

Joaquina, you are also from Palau. Can you tell us about your background, and who inspired your work?

JOAQUINA "KINA" ULENGHONG (PALAU): I've been in the nursing profession for the last 25 years. I've worked in clinical nursing and in public health now for the last 12 years. I'm a registered nurse and a nurse practitioner. I'm the Maternal and Child Health Care coordinator for the Republic of Palau.

My father was the person who inspired me to get into the nursing profession. When I was 10 years old, he had surgery and I had to attend him in the evenings when I finished school. Whenever I went to be with him at the hospital, the nurses seemed like angels to me. I asked my father, "How come the nurses are so kind and so caring?" I decided that someday I was going to be like them. When I got to high school I still had the desire. "I'm going to be a nurse, I'm going to be a nurse." And that motivated me to get into the nursing profession. I've spent 25 years in nursing and I'm still enjoying it. I like working with people and helping people in need.

I like working with people and helping people in need.

Thank you. Let's move along to Denitha.

Denitha Palemar (Yap): I coordinate the MCH program in Yap State. I was educated in business management and worked as a medical supply manager for over 10 years. About 18 months ago, I joined the Yap Public Health Department as a program coordinator.

Much of my inspiration for getting into public health came from my experiences living in the outer islands for two years. I watched babies die from dehydration. These terrible and unnecessary deaths affected me deeply. So when I had a chance to visit the center—Yap—and there was a training going on, I joined. I thought I might go back to the outer islands afterwards and help care for the people there. But I ended up staying in the center and working for public health.

Thank you. And now Roslyn, from Kosrae.

Roslyn Reynold (Kosrae): I am from Kosrae, one of the Federated States of Micronesia. I studied at Community College of Micronesia (CCM) in Pohnpei, and after I graduated I went back to Kosrae and worked for four years. Then I had the opportunity to earn a BSN at the University of Guam. I worked with special needs children through the Kosrae MCH program, and just this last two years have been the MCH coordinator.

What originally inspired me to go into nursing was my friends. We were together at CCM. They were talking about how much they wanted to be nurses. So I said, "OK, I'll be a nurse, too." We ended up taking courses together. It was a lot of fun.

But I also wanted to help my people. It's a challenge for me to know more of my communities, and to work with the people. That's why I'm here.

Thank you. Now we'll go to Andita, from Chuuk.

Andita Meyshine (Chuuk State): I'm the coordinator for Maternal and Child Health in Chuuk State. I've been in nursing a long time. I earned my AS degree way back in the 1970s from Northern Marianas College at CNMI (Commonwealth of the Northern Mariana Islands). Then I went on to graduate studies at Seattle University in Seattle, Washington, and I got my MPH in Hawai'i.

My mother was the source of my inspiration to go into the nursing field. I can remember when I was in elementary school, she was sick. I saw my mother suffering and in pain. The health assistant who was taking care of her really inspired me. I hoped that some day I would be able to help my mother. All through my high school years, I wanted to be a nurse. I wanted to get the education I needed to work in health, and to help my people back home.

I wanted to get the education I needed to work in health, and to help my people back home.

Thank you. And now Rosa.

Rosa Ayuyu (Saipan, Mariana Islands): I am from Saipan. I'm the proud grandmother of four. I'm a Carolinian—my ethnic origins are in the Caroline Islands. I worked in our only hospital in Saipan for 20 years. I've spent most of my time in public health. Before I moved to Honolulu, I worked in health education, and later the diabetes program. I ended up with the breast and cervical screening program when I came to Honolulu.

I got my inspiration in high school. We had a cooperative education program, and one of the counselors from Guam chose me for the career program. From 1968 until now, I've been working in health care.

Thank you, Rosa. Now we'll move on to Jacki from another island in the South Pacific.

Jacki Tulafono (Samoa): I'm from American Samoa. I've worked with MCH for the Department of Health for 4 years. Within the last year I've been appointed the program coordinator.

It's a little hard to pin down the inspiration for my work and studies. I was always interested in helping people and interacting with people but also had an interest in science. When I first went to college I was sort of going in the health direction but without real focus or energy. Then my brother became a health educator for the department of health. That gave me inspiration. I also had a very excellent college professor who inspired me to work in health.

Thank you Jacki. Now our panelist from the Marshalls.

Carmina Alik (Marshall Islands): I'm from the Republic of the Marshall Islands. I work as a medical liaison with the 177 Health Care Program. This program was started in 1954 by the U.S. Atomic Energy Commission to provide medical care to residents of the Marshall Islands who were exposed to fallout from nuclear testing at the Bikini Atoll.

We refer nuclear-affected patients to Honolulu for medical treatment they cannot get in the Marshall Islands. I've been working with the program since 1989. I took a few years off to get my BS degree when my husband went to do his residency in California.

My inspiration really had to do with my family. Families in Micronesia think health is an important field. I grew up thinking the health profession was the way to go. My husband's study of medicine also inspired me.

I'd like each of you to describe the important issues related to health disparities in your communities. In many cases, we do not have good epidemiologic data on our populations, so we have to rely on our experience to help us gauge the severity of different problems.

Jacki (Samoa): We come from a homogeneous population, although we have some other ethnic groups in Samoa. Health disparities exist not so much between the racially diverse community but in the socioeconomically diverse communities. We have different economic opportunities, health care access and educational and economic levels. With these challenges, it can be difficult for them to get care. Sometimes it's not apparent to people that they even need health care.

So I feel that one of the most important issues that is affecting health disparities is sociodemographics.

Andita (Chuuk State): For the island of Chuuk it's economics and resources—we don't have many. There are also outside influences. Most of the people are putting away their traditional cultures and the way they live and replacing this with the way of life from the outside. This has an effect on the health of the people.

People have to be educated, to become aware of our purpose and goals.

Roslyn (Kosrae): For the island of Kosrae the problem is education. People might not really understand what the health care programs are doing. For example, if we have very low immunization rates, we ask, "What is the cause of this low coverage?" I would say it is education. Some parents might wonder about immunization, but they don't really understand the risks if their children are not immunized. People have to be educated, to become aware of our purpose and goals.

I would also say that economics is a problem. We have only one type of insurance in Kosrae—FSM Group Health Insurance—and it only applies to working people. But most of the people in Kosrae are not working people. So people may not come to the hospital for financial reasons.

The western lifestyle creates diseases such as diabetes and hypertension.

DENITHA (YAP): The western lifestyle creates diseases such as diabetes and hypertension, especially in the island center, Colonia, where there are more stores with canned and frozen foods, things that are brought into the island. It's easily accessible to workers who have migrated from the other islands. Because they have a little money, they are more apt to buy this imported food which adversely affects their health.

Another disparity relates to accessibility of health care. A specialist or a doctor must go out to the other islands to provide services to much of our population. We have traveled several times with the Department of Health to the other islands. The request we repeatedly get from the women is, "When can a female doctor come out to see us?"

Patients also want more time to explain their problem confidentially. But the way that we are delivering health care now does not allow this. We spend so much time doing administration and other things. These are problems that I hope we will address in the future so the people feel they're being looked after.

KINA (PALAU): Certainly for Palau most of the health infrastructure is there, but access is not. Seventy percent of the population lives in the capital, Koror, and they have good access to services. It's the 30% out in the other islands who are not getting their full needs met. We've begun the process of bringing the services to them.

There are plans for a new road that will connect several of the islands. We anticipate another shift in the population when this is in place. More people will move to the outer islands. There are also plans to relocate the capital. We are working to strengthen the services on these islands now in preparation for the shift of population.

Selerina (Palau): The leading cause of death in youth is injury. There is a major drug problem in Palau that needs to be looked at.

Kina (Palau): Most of the injuries are preventable because they are usually alcohol and drug related. With the improvement of the road connecting the islands and with the dispersal of the population from the center, we anticipate more crashes, injuries and deaths in years to come.

Carmina (Marshall Islands): The issues in the Marshall Islands are primarily socio-economic and educational. In addition to what my colleagues mentioned, there's a very high rate of teenage pregnancy and diabetes in the islands. I believe much of this comes from the western way of life. People are eating more canned goods now and there's a lot of salt in the canned goods. They're not eating a lot of their traditional island foods.

I've gone on some trips to the outer islands with the missions and I found that a lot of the women have trouble getting their medical checkups because of custom. Their husbands are worried about who's examining them. It's fine if it's a female physician. Following through after lab results come back and following through with treatment can also be a problem.

Continuous health education is really needed to prepare people.

Rosa (Saipan): Continuous health education is really needed to prepare people. If they're living with diabetes, they need help knowing what to eat and how to measure their food. If we just say, "Reduce this, don't eat that," they question us.

I also see a financial crisis here. I'd like some sort of program in Saipan to make health care more affordable, and to lessen the burden on working people. Even with health insurance, if a family has four or more kids going to school and a minimum salary, they cannot afford to pay for their children's prescriptions. If they can't buy the medicine, the children cannot take the medicine. So people think, "What's the use of bringing my kids—or myself—to the hospital if the doctors cannot give us the medicine we need to cure the sickness?"

FAYE (GUAM): The majority of our Native people live on the islands, but there are many who are migrating. More and more Pacific Islanders are moving to Hawai‘i and California. In fact, you can find Pacific people in all 50 states.

Our patients on the islands may be referred to hospitals in Hawai‘i for care because we don't have adequate facilities in their home areas. As a result, many of our people are being served by non-islanders. And even our own people sometimes have problems in providing care.

What can we tell practitioners that might help reduce the disparities—even those who are working with patients in their home islands?

JACKI (SAMOA): One of the things that might be helpful is to look at people in the context of their lives. Often a person is coming to the clinic and presenting with a medical condition. The providers tend to look at that one condition and not see the person holistically. It helps when providers think about the situation this person comes from. That influences what kinds of advice or treatment is likely to work.

One of the things that might be helpful is to look at people in the context of their lives.

We may prescribe medications that are too expensive for a large family on limited income. This doesn't work. The provider is thinking, "I've done the best I can do clinically for this person." The patient is thinking, "I didn't get the help I needed."

Some of the most important issues are things that might not be medical—sometimes they're social, sometimes they're cultural, sometimes they are other things that go beyond what presents to you in the office.

Selerina (Palau): I agree with Jacki 100%. You should see the person not only physically but socially and economically. Then you see all the problems that person has.

Carmina (Marshall Islands): In the Marshall Islands a lot of physicians don't understand the culture. They run into trouble with patients. We also have different social classes and they get treated differently. That's important in our culture. And the doctors have to consider that too.

Andita (Chuuk State): When people from the islands come abroad for treatment or health care, I think it's important for providers to find out about the kinds of support that person has from the community. If you are just treating that individual, when they go back home, they may not have the resources they need to get well. The practitioner needs to find out if the person has support in the community to help out back home.

The practitioner needs to find out if the person has support in the community to help out back home.

Roslyn (Kosrae): Sometimes the problem doesn't come from the clinical practitioner but from the legal and health care systems. We must ask our lawmakers to establish laws that can help—such as resolving health disparities that arise in our health delivery in my island, Kosrae.

Kina (Palau): I think another important thing is to ensure continuity of care. For example, we might send a patient to Honolulu for chemotherapy. In such a case, the patient often ends up staying off their island for a long time. This has a negative impact on the family because they are separated. The person needs to continue care after returning to their island, but this may not be possible because the treatment isn't available there. This creates a real dilemma for patients. Do they receive the full course of care recommended and prolong the separation from their family?

FAYE (GUAM): We did some studies in Hawai‘i with some of the patients from the islands. One of the problems is that many don't complete treatment as recommended. They come here and start treatment, but when they're not satisfied or don't understand what is happening, they do not confront the issue or bring it up with their physicians. Instead, they depend on the authority of the physician to sense their discomfort, and to know how to deal with them. If the physician never brings the matter up, the patients become discouraged, or feel they are not understood, and they leave treatment.

This is a big gap in terms of the perceived role of physicians and the expectations of patients. Physicians who are dealing with Pacific people may need to address these matters with family members, and ask them about any problems, questions or complaints the patient has. They can also ask the family members to encourage patients to complete their treatment.

CARMINA (MARSHALL ISLANDS): As an interpreter, I have a responsibility to make sure that the patient knows all their options. I find that continuity of care is better if you give the responsibility to the patient.

I find that continuity of care is better if you give the responsibility to the patient.

We have a small clinic for our nuclear-affected islands. Rather than having the clinic follow through with all 4,000 patients, we give the responsibility to the patient. They often come back and say, "I think I'm suppose to go back to Honolulu for this." That works out better than having the clinic try to find a way to keep track of each person. The interpreter has a big responsibility to make sure that the physician and the patient can communicate.

FAYE (GUAM): Carmina, and skillful interpreters like her, tend to be the exception. Many times the interpreters are not knowledgeable. The interpreter needs to be familiar with the medical issues. If they're not, then you really have that gap of understanding.

Andita (Chuuk State): I think that's where our culture comes in. Because the physician needs to understand where a person is coming from, what kind of culture. Many of our people sit back waiting for the physician to tell them everything. They don't come out and say, "Excuse me, what happened? I want to know about my illness." They just come to get the treatment and they look up to this physician as someone who knows everything.

If the patient is quiet, maybe the family needs to come in and ask questions. The physician needs to allow that. If a patient is not talking, the physician could find out who that person is with and get some help with the conversation. The physician needs to be sensitive to our Pacific Island culture.

The physician needs to be sensitive to our Pacific Island culture.

Jacki (Samoa): It's very intimidating for people who are coming a long distance for care. You are taking them out of their element. Even at home, it's difficult for us to help patients follow through on whatever services or care they need.

If we speak to our clientele like we're partners, and we're going to do this together, then maybe they'll understand that the responsibility is not all on one party. In order to make the most out of their visits, they need to know that it's OK for them to say no sometimes. Or it's OK to say, "I don't like what you're doing," or to ask questions, or to advocate for themselves.

Faye (Guam): We need to educate our patients to be consumers and be able to, not necessarily demand, but seek the kind of services they need or want. That's also an education process.

Denitha (Yap): One of our doctors has a unique approach in dealing with patients. The tone of his voice, how he talks with the patients is totally different from the rest of the doctors. He spends more time. He projects that sense that he cares about the patient. Now we're getting more and more patients who come in and say, "I want to see him."

Health practitioners in Hawai'i should do the same thing with Pacific Islanders, especially someone coming from Yap. The culture and all the technology and things—when the health provider is zooming here and there and here and there—the person is just lost. Pacific Islanders deal with each other in a very culturally specific, personal way. For us to be dealing with outsiders is quite different and sometimes our people get frantic. The wrong attitude can turn people away.

Pacific Islanders deal with each other in a very culturally specific, personal way.

FAYE (GUAM): Patients need time to build trust and confidence in health care providers in order to open up and ask questions. This can be hard outside our islands where the doctor's time is a precious commodity. I think providers could learn more about how to educate patients, to empower them in terms of when they are going to see a doctor, what they should do and how they should approach their doctor.

JACKI (SAMOA): Another thing that might help providers is asking the patients about their expectations. Sometimes the patients are not realistic. They don't know what to expect and can be disappointed.

I understand that my mother has these expectations when we go to the doctor's office. She's sitting there and everything is cordial and fine. Then we leave the doctor's office and I'm thinking she is happy with the way things went. Oh, she has a list of complaints. "He didn't do this and he didn't do that and I didn't like this, and…." Sometimes those concerns are valid but much of the dissatisfaction stems from the expectation of what the patient brings in to the doctor's office.

I think we have had a rich look at some of the issues related to health disparities. What are some of your hopes for the future? What would you like to see happen to eliminate disparities?

KINA (PALAU): My dream is to have specialists and diagnostic services on all the islands so we don't have to spend our health budget on travel.

Selerina (Palau): I hope we will have better health for the people in the Pacific, and that the people will look at health not in terms of disease but as well-being.

Andita (Chuuk State): My hope for the future is to have a place for our new generation of children, and that they will grow up and maintain the traditions we have had in the past that have been good for us. I hope we will not replace what we have with things we want that negatively affect the health of our people.

I also hope we can prevent illnesses we don't currently have in the islands from coming to our people, such as HIV. I hope we can educate our people to prevent its spread, and also that we will support each other if it does appear in our islands.

I hope we will have better health for the people in the Pacific, and that the people will look at health not in terms of disease but as well-being.

Roslyn (Kosrae): What I hope for the future is that we use the resources we have to solve the problems of health disparities in Kosrae. I would like our focus to be more on prevention, so we don't have to rely so much on the treatment or curative part of our efforts.

Denitha (Yap): My hope is that the women and youth of Yap would go beyond a high school education. Since women are the first teachers of children, they can prevent many of these problems if they are well educated. To have a well-educated community—especially women—would be a dream realized.

Carmina (Marshall Islands): I think that the Marshall Islands really needs to be more medically self-reliant. Our hospital sends out quite a few referrals to Honolulu. We also need to inspire high school students to get into the medical field—and then give them incentives to come back home and work in our hospital.

Rosa (Saipan): I hope that 10 years from now, more of our boys and girls will have an interest in health studies and specialize in many areas—so we can decrease our referrals to other states. This will reduce our financial crisis by limiting referrals away from Saipan. Instead, we will be receiving the referrals from sister islands. Continuing education is also very important.

FAYE (GUAM): We must remember that these islands are thousands of miles away from the main center. Evacuating patients to Hawai'i is not only costly, but creates a gap of distance and time before people can receive services and begin to get well.

JACKI (SAMOA): In the future, I hope people value health as much as money or education. People value life but don't think of life in terms of their health.

KINA (PALAU): I wish more money and effort were put into disease prevention. This would reduce many health disparities we're facing—and reduce the cost of hospitalization and sending patients to other islands.

To summarize, you have all mentioned factors such as education, prevention and building infrastructure for health on the islands, as well as educating people about the choices they can make as patients to improve their care. Also, improving the quality of life—the water, the food—on the islands would make the people a lot more healthy.

Thank you all for sharing your experiences and expertise.

Recommendations

The elimination of health disparities will require a concerted effort by individuals and institutions in the public health community and beyond. Reliable data about the health status of specific populations is essential to this endeavor. There are data sets being developed by the Federal Government, state and regional entities, and various health care organizations. Some of that data is included in the introduction to this publication. Using this data and other information, different recommendations have been developed to guide the effort to eliminate disparities.*

One thing becoming evident is that data alone will not be enough to accomplish the task. To effectively reach populations affected by disparities, providers need to have a personal understanding of the communities and people within those populations—who they are, what matters to them and how they can be supported in building a stronger foundation for health. To achieve meaningful change in American health care, data about disparities must be linked to experience and wisdom about people, and power must be shared. This bringing together of science and wisdom, data and heart, has been one of our primary goals in offering these interviews.

The leaders who have shared their ideas, experiences and inspiration with us here have articulated a set of recommendations critical to success in eliminating health disparities among Pacific Islanders.

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*See, for example, *Revised CLAS Standards from the Office of Minority Health*, outlining 14 recommendations for culturally and linguistically appropriate services, at www.omhrc.gov/CLAS; and *Healthy People 2010, 2d ed.*,U.S. Department of Health and Human Services, Washington DC.

General Recommendations

- Improve the quality and thoroughness of data collection on Pacific Islanders in the U.S. Census and in surveys concerning health, social issues and economics. Recognize distinct ethnic groups when gathering data, and avoid aggregating data on Pacific Islanders with data on Asians, as this often obscures true health status.
- Emphasize primary health care and bring a strong focus to disease prevention efforts.
- Support the establishment of locally run health centers that provide culturally appropriate, high-quality comprehensive health care.
- Use community-based approaches to identify and design health research. Involve members of the community in establishing priorities, goals and methods.
- Bring particular attention to the issue of diet. Help Pacific Islanders reestablish more traditional and healthful diets, and decrease their reliance on high-fat, high-salt western diets.
- Develop better access to health care. This includes increasing the availability of insurance, and creating a system of care that is welcoming and sensitive to the traditions of the various Pacific Island cultures.
- Develop effective strategies to address common barriers to health care for Pacific Islanders, such as affordability of insurance, transportation, communication, fear of doctors, and misunderstandings about preventive health care. Support the training and use of skilled and effective translators.
- Help Hawaiians maintain or recover access to areas where they can gather traditional foods and medicines and experience their traditional connection to the land. Emphasize land use that is sustainable rather than profitable.
- Provide economic and practical support for the improvement of health care facilities, staff and capacities, particularly in the more remote islands.
- Use opportunities to mentor others, and encourage young people to pursue careers in health. Provide focused support to Pacific Island students when they enroll in programs away from home.
- Patience is an essential quality in the delivery of health care. Many Pacific Island patients find it difficult to ask questions of providers. Providers may need to make special efforts to be sure patients understand assessment, diagnoses and instructions for care, as well as elicit further patient questions or concerns.

Nellie Rising Sgambelluri

- Support health students' studies in program planning and evaluation—essential skills for starting programs in underserved areas with limited resources.
- Integrate medicine and public health in ways that bring together the strengths of each profession and benefit Pacific-Island communities.

Puaalaokalani D. Aiu

- Know where you want to go and develop a clear vision so you don't get sidetracked by politics and others' agendas.
- Use the rules of the culture to reinforce positive choices about health, such as a healthful diet, taking time to manage stress, and connecting with family and community.
- Support access to natural places for Hawaiians and participation in traditional activities as a way to address stress.

Kekuni Blaisdell

- Support the establishment of a clear, positive self-identity in *Kānaka Maoli* people. Promote *Kānaka Maoli* traditions that support better health among the people—traditional diets, reverence for the natural world, commitment to family and ceremonial practices.
- Providers have a responsibility to bring science to their patients, by clearly interpreting medical diagnoses. Providers must teach about these things in ways their patients can understand.
- Providers must learn from their patients, as well as teach.

Eliuel K. Pretrick

- Providers in the Pacific Islands must share information about diseases and epidemics, and notify each another about problems that emerge on one island so that appropriate steps can be taken to prevent outbreaks on other islands.
- It's vital that Pacific Islanders who travel to the United States to work or study understand the importance of health insurance.

- Health status will be enhanced if the government can continue to provide basic services, such as immunization, and ensure sufficient supplies and equipment in pharmacies and hospitals.

Merina Sapolu

- Class issues influence health care access and delivery. Providers, clinics and agencies must avoid actions that suggest bias against people of lower socioeconomic status, and ensure that everyone feels welcome. Providers must see patients as equals, and treat everyone with respect.
- Advocates and educators can help Pacific Islanders build a greater appreciation for the value of health, and the importance of their involvement in their own health care.
- Media campaigns can be effective with Pacific Islanders, because most listen to radio or watch TV. It's also important to have written health education materials in many languages.

Faye F. Untalan

- When health care funding is provided to Pacific Islands, local providers should be given the flexibililty to design programs around local needs. The federal government should be more cognizant of the ways health care funding affects people in remote areas with different cultures, needs and resources.
- Continuity of care is important. People will build trust with a provider when they can see the same person and build a relationship over time.
- Reciprocity is an important concept for many Pacific Islanders. When providers accept small gifts from their patients, they help establish a stronger sense of connection.

Discussion Group

CARMINA ALIK

- Providers should make sure patients know all their options, and empower them to take responsibility in choosing their care.

Rosa L. Ayuyu

- Building more interest in health careers among children and youth today will allow them to help provide better health to the people in the future, and decrease the need to refer people to other states for care.

Selerina Malsol

- Providers need to build a greater sense of health as a state of well-being, rather than an absence of disease.

Andita Meyshine

- Help the next generation of children grow up maintaining the traditions of the past that have been good for people's health and well-being.

Denitha Palemar

- Pacific Island women need greater opportunities for education. As the primary educators of their children, women have the capacity to prevent many health problems and disparities.

Roslyn Reynold

- People need to be educated about and understand the purpose and goals of health providers and programs.

Jacki M. Tulafono

- Providers must see people in the context of their lives, holistically. It's important to determine who will help a patient follow through on the plan for care, and to know whether the family is supportive.

Joaquina Ulenghong

- In Palau, it is important to address high rates of injury, which are often related to alcohol and drug use.

Resources

History and Culture

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- Rezentes, W. C. 1996. *Ka Lama Kukui Hawaiian Psychology: An Introduction*. Honolulu: A’alii Boo.

Information and Support

- Pacific Islands Report. A news service providing news reports from Pacific Islands throughout the pacific.
  http://pidp.eastwestcenter.org/pireport

Talking About Health

- Diversity Rx: Resources for Cross Cultural Health Care
  www.diversityrx.org/html/wercch.htm
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Health Issues and Demographics

- Asian & Pacific Islander American Health Forum (APIAHF)
  www.apiahf.org
- Centers for Disease Control and Prevention
  www.cdc.gov
- Healthfinder®
  Office of Disease Prevention and Health Promotion
  U.S. Deparment of Health and Human Services
  www.healthfinder.gov/justforyou
- National Center for Health Statistics
  www.cdc.gov/nchs
- Office of Minority Health
  www.omhrc.gov/OMH/sidebar/aboutOMH.htm
- Pacific Health Dialogue:
  Journal of Community Health and Clinical Medicine for the Pacific.
  www.resourcebooks.co.nz/phd/phd/htm
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  www.census.gov
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Eliminating Health Disparities

Conversations with Pacific Islanders

is one of a series of *Public Health Profiles* published by ETR Associates, a private, nonprofit agency committed to providing health education/promotion resources for underserved populations. Each book in the series focuses on a cultural group that has traditionally experienced health disparities, profiling leaders working to promote health and prevent disease. The content includes background information on existing disparities and recommendations to improve practice and outcomes in the future.

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