

Challenges and Promise of Health Equity for Native Hawaiians

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October 31, 2016

Health equity, the attainment of the highest level of health for all people, is yet to be realized for many populations in the United States. Health equity focuses on diseases and health care services, but is also broadly linked to social determinants, such as socioeconomic status, the physical environment, discrimination, and legislative policies. For one population, Native Hawaiians, the indigenous people of Hawai'i, the elusiveness of health equity is reflected in the excess burden of health and social disparities.

The experience of health disparities for this native population is even more troubling as Hawai'i, with its diverse multiethnic population, is reputed to be the "healthiest state in America" (United Health Foundation, 2014). This paper provides a perspective on health equity for Native Hawaiians by reviewing population characteristics, identifying prominent health and social disparities, presenting programs that show promise for health equity, and concluding with recommendations for the future.

Population Characteristics

Census

In 2010, 5.2 million people in the United States identified as American Indian and Alaska Native, representing nearly 2 percent of the nation's population (Norris et al., 2012). In that same year, 1.2 million people identified as Native Hawaiian and other Pacific Islander (NHPI), with the largest groups being Native Hawaiian (527,000), Samoan (184,000), and Chamorro or Guamanian (148,000) (Hixson et al., 2012). There were 156,000 people reporting Native Hawaiian as their sole racial category and an additional 371,000 people reporting Native Hawaiian ancestry in combination with

another race. Seventy percent of Native Hawaiians reported being multiracial with one or more other races. Although Native Hawaiians had the largest numeric increase (126,000) from 2000 to 2010 among all NHPI groups, they continue to grow at a slower rate than other NHPI groups. This slower growth, coupled with the rapid growth in other NHPI groups, caused the Native Hawaiian proportion of the overall NHPI population to decline from 46 percent in 2000 to 43 percent in 2010 (Hixson et al., 2012). More than one-half (55 percent) or roughly 290,000 Native Hawaiians live in Hawai'i, making up approximately 21 percent of the state's multiethnic population of 1.4 million. California and Washington hold the second and third highest Native Hawaiian populations, respectively (Hixson et al., 2012).

Historical Background

One cannot begin to understand the health inequities of the Native Hawaiian people without first having an awareness of their history. The arrival of Captain James Cook in Hawai'i in 1778 represented one of the earliest contacts of Native Hawaiians with the Western world. Within the first 100 years of Western contact, the Na-

tive Hawaiian people would experience a 90 percent decrease in population due to the introduction of new diseases, such as tuberculosis, measles, smallpox, and syphilis (Kana'iaupuni and Malone, 2006; McCubbin and Marsella, 2009). Western contact increased as missionaries and whaling ships arrived at the islands. These missionaries developed boarding schools, removed Hawaiian children from their native homes, and strictly enforced Christianity, English, and Western culture (McCubbin et al., 2008). The practice of Hawaiian language and culture would continue to be disdained as primitive and pagan. As nonnative contact increased, Native Hawaiians began to lose possession of their land, politics, and economy. Because of the decline in the Native Hawaiian population, foreign laborers were hired, during the mid-1800s, to work in the sugar and pineapple industries. These laborers (from China, Japan, Portugal, the Philippines, and Puerto Rico), along with missionaries and businessmen, eventually outnumbered the Native Hawaiians. The gradual loss of people, culture, and land culminated in 1893 with the forced removal of the Hawaiian queen by a U.S. military-backed group of businessmen and missionary descendants (Kana'iaupuni and Malone, 2006). Without a vote from the general citizenry and amidst Native Hawaiian protest, Hawai'i became a territory of the United States in 1898 (McCubbin et al., 2008; Schamel and Schamel, 1999). It achieved statehood in 1959.

The U.S. government has made several attempts to make amends for the illegal overthrow of the Hawaiian monarchy. These included the 1921 Hawaiian Homes Commission Act, the 1951 ceding of Hawaiian lands, and the 1993 formal apology to Native Hawaiians via Public Law 150 (*100th Anniversary of the Overthrow of the Hawaiian Kingdom*, Public Law 150, 103rd Congress, 107 Stat. 1510, 1993; McCubbin et al., 2008). Although these acts have not led to improved conditions for the Native Hawaiian people, they have contributed to revived interest in Native Hawaiian customs and the Native Hawaiian sovereignty movement. During the early 1970s, especially, Native Hawaiians gained a renewed interest and pride in their traditional culture and in improving their social conditions. Beginning with protests against land abuses, the exploitative conditions of Native Hawaiians, and claims to birthrights, the Native Hawaiian sovereignty movement evolved to include goals of self-government, the creation of a public education system in the Native Hawaiian language, and le-

gal entitlements to a national land base, including water rights (Trask, 1999). Public Law 150 identified the 1893 overthrow of the Native Hawaiian government as "illegal," called for reconciliation between the United States and the Native Hawaiian people, and identified the resilience of the Native Hawaiian people to preserve their cultural identity. This resolution especially emboldened Native Hawaiian sovereignty supporters. In 2000 the Native Hawaiian Reorganization Bill, also known as the Akaka Bill, was introduced with the goal of initiating a process by which a Native Hawaiian governing entity would be recognized by the United States (U.S. Congress, Senate, Committee on Indian Affairs, 2005). Although several revisions to the bill have been made, it was voted down by the U.S. Senate. Today, many Native Hawaiians continue to call for self-determination and self-governance.

Impact of Historical and Cultural Losses on Health

The Native Hawaiian experience has often been likened to that of the Native American, especially when addressing the effects of historical events on the current health and overall well-being of these groups. Both groups have experienced a colonizing majority who has subjugated them to long-term injustice and discrimination (Duran and Walters, 2004). The terms historical or multigenerational trauma/loss describe the cumulative impact of this colonization, oppression, and cultural suppression that continue to impact these groups' quality of life (Kirmayer et al., 2014). Even President Clinton, in his 1993 apology to Native Hawaiians, noted the "devastating" effects that Hawai'i's historical experiences have left on its people (Public Law 150). These losses include the following: loss of their original agricultural and aquacultural way of life due to urbanization (Liu and Alameda, 2011), the replacement of the Hawaiian language with English in legal and educational settings (Liu and Alameda, 2011), limited access to Native foods due to cost and restricted land use policies, and relegation of native culture to Western depictions of Polynesian culture for tourist advertisements (Kana'iaupuni and Malone, 2006). Although the overthrow of the Kingdom of Hawai'i occurred more than a century ago, historical loss of population, land, culture, and self-identity have shaped the economic and psychosocial landscapes of Hawai'i's people, and limits their ability to actualize optimal health.

Health Disparities

The Native Hawaiian population experiences numerous social and health disparities. In Hawai'i, Native Hawaiians have the shortest life expectancy and exhibit higher mortality rates than the total population due to heart disease, cancer, stroke, and diabetes. Poor health is inextricably linked to socioeconomic factors, and Native Hawaiians are more likely to live below the poverty level, experience higher rates of unemployment, live in crowded and impoverished conditions, and experience imprisonment (Naya, 2007; OHA, 2010). Noteworthy and disturbing are the high percentage of Native Hawaiians who are homeless in their own island homeland (Yamane et al., 2010). As many Native Hawaiians hold a holistic view of health in which family, community, land, and spiritual realms are interrelated, the cultural trauma/loss that continues today greatly impacts this group and is manifested in their many health disparities. In context of the numerous health and social disparities confronting Native Hawaiians, we highlight a few disparities with significant impact.

Cardiovascular and Cerebrovascular Disease

Cardiovascular disease (CVD) includes coronary heart disease (CHD) and cerebrovascular disease resulting in stroke. CHD and stroke are the first and third leading causes of death for Native Hawaiians, respectively (Balabis et al., 2007). Compared to other ethnic groups in Hawai'i, the prevalence of CHD has increased over the past 4 years for Native Hawaiians (currently at 4.2 percent), which is twice that of European Americans and three times that of Japanese Americans. Similar trends are seen for stroke, the prevalence of which in Native Hawaiians has also been increasing to twice that among other ethnic groups in Hawai'i. Native Hawaiians are also afflicted by stroke an average of 10 years younger than others (Nakagawa et al., 2013). Hypertension and obesity are CHD and stroke risk factors and they are also disproportionately higher for Native Hawaiians (Nguyen and Salvail, 2013). Studies have linked the higher prevalence of hypertension and obesity to perceptions of racism in Native Hawaiians (Kaholokula et al., 2010; McCubbin and Antonio, 2012). Overall, Native Hawaiians have among the highest mortality rates due to CVD with rates 34 percent higher than the general population (Balabis et al., 2007).

Cancer

As with other populations, cancer is the second leading cause of death for Native Hawaiians. However, troubling variations in incidence and mortality rates for the leading cancer sites are observed for Native Hawaiians. In Hawai'i, when compared with the other major ethnic groups, the overall cancer incidence rates were highest for Native Hawaiian women, and overall cancer mortality rates were highest for both Native Hawaiian men and women (American Cancer Society, Cancer Research Center of Hawai'i, and Hawai'i Department of Health, 2010). The leading cause of cancer death for all populations is lung cancer, but in Hawai'i, it is highest for both Native Hawaiian men and women. Despite improvements in breast cancer prevention and treatment, Native Hawaiian women continue to have the highest incidence and mortality rates. The explanations for these disparities relate to external, internal, and lifestyle factors (Imi Hale, 2015), and could include the lack of culturally appropriate interventions, late detection, diagnoses at more advanced stages, genetic markers of tumor aggressiveness, and high prevalence of tobacco use (Mokuau et al., 2012). Examples of culturally tailored interventions include home-based family education, a screening intervention in a church setting, and hospital-based patient navigator programs (Imi Hale, 2015; Ka'opua et al., 2011a; Mokuau et al., 2012). The undeniable improvements in cancer diagnosis and care in the last several decades will need further refinement to effectively impact cancer disparities in the Native Hawaiian population.

Diabetes

The prevalence of diabetes when based on self-report of its diagnosis is twice that of European Americans (11.6 percent vs. 5.1 percent) and higher than among other ethnic groups and the general population (Nguyen and Salvail, 2013). When based on actual screening for diabetes, its prevalence for Native Hawaiians nearly doubles because just as many have the disease but are unaware as those who have been diagnosed, and the gap between them and European Americans widens by fourfold (Grandinetti et al., 2007). Overall, the mortality rate due to diabetes in Native Hawaiians is twice that for the entire state of Hawai'i (Johnson et al., 2004). As noted earlier, the prevalence of obesity, a major risk factor for diabetes, is higher among Native Hawaiians than other ethnic groups.

Large within-group differences in the risk for diabetes among Native Hawaiians have been found in relation to acculturation modes. It has been theorized that people who undergo an acculturation process, whether voluntarily or involuntarily, eventually settle into a mode of acculturation to adapt to the demands of the dominant mainstream, and the mode they settle into can affect their mental and physical health status (Berry, 2003). They can settle into one of four acculturation modes: (1) an integrated mode in which they identify highly with both their traditional ethnic heritage and the dominant mainstream cultural group, (2) a separatist mode (referred here as traditional mode) in which they identify highly only with their traditional ethnic heritage, (3) an assimilated mode in which they identify highly only with the dominant mainstream cultural group, or (4) a marginalized mode in which they do not strongly identify with either their traditional ethnic or the mainstream cultural group.

Seventy-seven percent of Native Hawaiians are found to be in an integrated mode, 17 percent in a traditional mode, 4 percent in a marginalized mode, and 2 percent in an assimilated mode (Kaholokula et al., 2008). When comparing across the two most frequent acculturation modes, the prevalence of diabetes is as high as 27.9 percent for Native Hawaiians in a traditional mode compared to 15.4 percent for Native Hawaiians in an integrated mode (Kaholokula et al., 2008). It is hypothesized that these acculturation modes are markers of the degree of psychosocial stressors (e.g., discrimination) and cultural discord (e.g., policies that restrict one from practicing his or her culture) differentially experienced by Native Hawaiians, which places some at a greater risk for diabetes than others (Kaholokula et al., 2009).

Substance Abuse

Substance abuse and dependence are prominent health concerns for Native Hawaiians. Rates of illicit drug use are among the highest for Native Hawaiians, with evidence that they are increasing. Among persons age 12 or older, illicit drug use for Native Hawaiians or other Pacific Islanders was 3.5 percent in 2013 and 5.2 percent in 2014, compared with national averages of 2.6 percent and 2.7 percent, respectively (SAMHSA, 2015). In 2014, the rate of substance abuse or dependence (illicit drugs or alcohol) was 10 percent for Native Hawaiians or other Pacific Islanders and 8.1 percent for the nation. Further, emerging information

indicates that mixed-race groups, such as Native Hawaiians, are at greater risk for substance abuse (Wu et al., 2013). Substance abuse in the Native Hawaiian population is associated with an array of social and behavioral problems including higher rates of depression and suicide, unsafe sexual practices with multiple partners, increased violence in multiple settings, and a disproportionate burden from incarceration (Edwards et al., 2010; Nishimura et al., 2005; OHA, 2010). There are multiple and complex explanations for these disparities when compared to other populations, including higher social, environmental, and economic risk factors; poorer access to care; and inappropriate care—(SAMHSA, 2015).

Aging

The United States is experiencing rapid growth in its older population with estimates suggesting that by 2030 more than 20 percent of the nation's residents will be age 65 years and older (Ortman et al., 2014). In Hawai'i, residents have the greatest longevity of all 50 states (Lewis and Burd-Sharps, 2014) and report the "highest well-being" for older adults in the nation (Gallup-Healthways, 2015). Yet, in harsh contrast, Native Hawaiians have the shortest life expectancy of the major ethnic groups in Hawai'i (Ka'opua et al., 2011a). Native Hawaiian older adults experience disparities in heart disease, cancer, and diabetes and increasing problems with dementia and Alzheimer's disease. They tend to live with families, and, although there is family desire and interest to provide elder care, emerging issues of caregiver burnout and stress are increasingly being reported. Health and caregiving needs of older Native Hawaiians exceed the availability of services, but often the services available show low utilization. In a qualitative study using listening sessions, Native Hawaiian elders and their caregivers identified services of priority, including transportation, caregiver respite, and caregiver education (Browne et al., 2014). Caring for Native Hawaiian elders translates into supporting them aging at home and in their community, with sufficient resources to strengthen family centeredness.

Promise of Health Equity

When asked to describe important aspects of their health, Native Hawaiians described cultural knowledge and practice to be of main importance (McMullin, 2005). They believe that a balanced system that integrates all aspects of the self (biological, psychological,

social, cognitive, spiritual) with the world (individual, family, community, environment) brings about optimal health (McMullin, 2005; Mokuau, 2011). Native Hawaiian cultural values and beliefs are organized around the collective relationships of the family, community, land, and spiritual realm. We present three examples of model programs in which these factors are integrated, enhancing their receptivity, acceptability, and relevance to the intended Hawaiian constituencies. These programs leverage pivotal legislation and policy (Papa Ola Lōkahi), demonstrate innovative research infrastructure to build indigenous research capacity (RMATRIX II), and implement progressive community-relevant interventions (PILI and HELA). With these model programs, there is the potential for health impact through policies that increase the Native Hawaiian workforce in health care, tailor research to specifically examine and treat health disparities among Native Hawaiians, and develop new clinical interventions that are community based and culturally anchored.

Papa Ola Lōkahi

The landmark E Ola Mau: The Native Hawaiian Health Needs Study (ALU LIKE, Inc. 1985), the first comprehensive health assessment of the Native Hawaiian community, identified health status, needs, and concerns of Native Hawaiians and related them to historical and cultural frameworks. That study reported that Native Hawaiians have some of the poorest health indicators in the nation. In concert with these findings, the U.S. Congress enacted the *Native Hawaiian Health Care Act of 1988* (Public Law 579, 100th Cong.), establishing Papa Ola Lōkahi (POL), a community-based/community-placed consortium to administer the act and “raise the health status of Native Hawaiians to the highest possible level.” Three major initiatives are highlighted. The first was establishing five individual, community-based Native Hawaiian Health Care Systems (NHHCS) that include Hui Mālama Ola Nā ‘Ōiwi serving Hawai‘i island, Hui No Ke Ola Pono (Maui island), Na Pu‘uwai (Moloka‘i and Lāna‘i islands), Ho‘ōla Lāhui Hawai‘i (Kaua‘i island), and Ke Ola Mamo (O‘ahu island). The NHHCSs provide a range of health and social services reaching over 30,000 annually. The second initiative is the Native Hawaiian Health Scholarship Program (NHHSP), established to address the paucity of Native Hawaiian health professionals. Since 1991, over 250 Native Hawaiians have received scholarship awards to support education in almost 20 different primary and

behavioral health care disciplines. More than 200 have been placed in the health care workforce in medically underserved communities in Hawai‘i. The third initiative is POL’s Native Hawaiian Health Master Plan which was first completed in 1989 and is periodically updated. The current Master Plan initiative, Ke Ala Mālamalama I Maui Ola involves over 50 community and clinical partners, working across disciplines and sectors to update and achieve a shared vision on improving Native Hawaiian well-being and guide POL’s role and responsibilities as the Native Hawaiian Board of Health (Akau et al., 1998; Papa Ola Lōkahi, 1998, 2015).

RMATRIX-II

Innovative research with its broad goal of creating new knowledge is essential in the commitment to eliminate health disparities among Native Hawaiians. RMATRIX-II (2014-2019) (1) is a research program funded by the National Institute on Minority Health and Health Disparities at the University of Hawai‘i at Mānoa (UHM). RMATRIX-II is a continuation of a U54 clinical and translational research grant award begun in 2010 (as RMATRIX-I). The research program provides an infrastructure for research that improves island health, particularly among Native Hawaiians, Pacific Islanders, and Filipinos. The infrastructure is intended to deepen the relevance of health disparities research and consists of resources on biostatistics and health sciences data analytics, clinical research resources, regulatory knowledge, professional development, collaborations and partnerships, and community-based work. RMATRIX-II uniquely blends the senior leadership of the UHM John A. Burns School of Medicine with the Myron B. Thompson School of Social Work to provide a strong platform for interprofessional research in health. A major commitment of RMATRIX-II is to develop cross-disciplinary junior researchers in health disparities, especially those from underrepresented backgrounds. To date, diverse fields of study at UHM with a common goal of improving health have participated, including medicine, social work, nursing, public health, law, tropical agriculture and human resources, business, engineering, pharmacy, education, and Hawaiian knowledge. RMATRIX-II invests in research that responds to high density Native Hawaiian communities such as Papakōlea, Waimānalo, and Wai‘anae. Requisite to these communities are priority research areas of nutrition and metabolic health; growth, development and reproductive health; and aging and

chronic disease prevention/management. Since its inception in 2010, RMATRIX I and II have supported investigators who have produced over \$25 million in contracts and grants, published over 150 articles, and presented at over 80 conferences in diverse areas of high need for Native Hawaiian communities, such as childhood obesity, teen pregnancy, diabetes, AIDS/HIV, dementia, heart disease, and cancer.

PILI and HELA

Several effective community-based and culturally relevant health promotion programs have been developed for Native Hawaiians and other Pacific Islanders to address excess body weight and improve diabetes and hypertension self-care. For example, the community and academic researchers of the Partnership for Improving Lifestyle Intervention (PILI) 'Ohana Program (2) developed the PILI Lifestyle Program (PLP), a 9-month and 12-month healthy lifestyle intervention, and Partners in Care (PIC), a 3-month diabetes self-care intervention using community-based participatory research approaches. They were designed to be delivered by community peer educators in a group format across various types of community settings (e.g., community health centers as well as homestead communities). Both the PLP and PIC have been extensively tested via randomized controlled trials and found to lead to significant weight loss for Native Hawaiians with excess body weight (Mau et al., 2010; Kaholokula et al., 2013) and improvements in blood sugar levels for those with diabetes (Sinclair et al., 2013), respectively. The PLP was also found to improve both systolic and diastolic blood pressure.

The community and academic partners of the Hula Enhancing Lifestyle Adaptation (HELA) Project (3) designed a hypertension self-care program centered around hula, the traditional dance of Hawai'i (Look et al., 2012; Maskarinec et al., 2014). This program is called *Ola Hou i ka Hula* (translates as "regaining life" through hula) and it was found to significantly reduce systolic blood pressure by 10.7 mmHg for Native Hawaiians with hypertension when compared to a comparable wait-list control (Kaholokula et al., 2015).

Recommendations

We have provided a perspective on the growing body of evidence documenting the health disparities among

Native Hawaiians as well as the programs and interventions that show promise in the attainment of health equity. For Native Hawaiians to eventually achieve health equity, there are several interrelated requirements. First, there must be an institutional commitment by universities and, in particular, the University of Hawai'i, to train a sufficient number of Native Hawaiians in all disciplines to address health disparities and create health solutions. This quest was begun by the John A. Burns School of Medicine in the early 1970s with its special premedical school initiative and has now been embraced by the other health care disciplines, including nursing, social work, and public health. Second, there must be the establishment of culturally sensitive health care systems that will affirmatively seek out Native Hawaiian patients, as envisioned under the Accountable Care Organization (ACO) and Patient-Centered Medical Homes provisions of President Obama's *Patient Protection and Affordable Care Act* (Public Law 111-148, 124 Stat. 119, March 23, 2010). The Queen's Medical Center has historically played this role and, over time, several Native Hawaiian-administered organizations, such as Papa Ola Lōkahi (established in the late 1980s) and I Ola Lāhui, were established to provide culturally minded assessments and clinical interventions, as well as clinical training sites and/or scholarships for the next generation of Native Hawaiian providers. The latter program provides specialized postdoctoral psychological training expertise emphasizing the importance of integrating the psychosocial-cultural-behavioral elements of quality health care, especially for those with chronic conditions. Services that are culturally sensitive will include attention to dietary needs, community relationships, and cultural/spiritual values as well as the potential for the use of indigenous plants and herbs as medications. The neighbor islands of Hawai'i represent rural America with all of the traditional challenges of access, provider burnout, and insufficient specialty care—effectively using telehealth care will be necessary to address these issues (IOM, 2005).

Third, it is essential that there be a serious appreciation for the complexity of Native Hawaiian culture at the policy level, or it will be very difficult, if not impossible, to affirmatively impact the historical pattern of adverse health consequences. Further, one must reasonably expect that it will not be in the foreseeable future

that our nation's provider-oriented approach to health care reimbursement will allocate sufficient financial resources for such a fundamental change in orientation, notwithstanding its importance. Native Hawaiian-administered programs represent a unique opportunity for the indigenous people of Hawai'i to control their own health care destiny. With the enactment of the Native Hawaiian Health Care and Education Acts, considerable federal funding has been made available over the past several decades for these purposes. Much of the federal financial support they receive is not directly tied to the specific amount of clinical services provided and are instead programmatic in nature, and thus can be the basis for necessary infrastructure support. Hopefully, over time, each of the programs will be successful in obtaining additional support from interested foundations, Medicaid, and private health insurance contracts.

The recent Native Hawaiian renaissance, as a direct result of the collective passion generated by the voy-

age of the Hōkūle'a, demonstrates the critical importance of culturally sensitive interventions. At the same time, it is important to appreciate that although over the past four decades there have been more than 150 federal statutes recognizing Native Hawaiians, these are "stand-alone" in nature and rely almost exclusively on federal domestic discretionary funds for implementation. It is worth noting here that the Departments of the Interior and Justice have published a proposed rule making to establish a government-to-government relationship with the Native Hawaiian people in a fashion similar to that of Alaska Natives and Native Americans. In addition to this rule making, action at the local level continues to be heavily debated on the Na'i Aupuni process, in which Native Hawaiians are discussing government reorganization and sovereignty. Certainly one question facing any reorganized Native Hawaiian government will be the continued health care and well-being of its citizenry.

Background

This discussion paper was stimulated by conversations at a meeting on May 11, 2015, convened by the Board on Children, Youth, and Families of the National Academies of Sciences, Engineering, and Medicine. A number of discussion papers arose from this meeting and will be published as NAM Perspectives throughout 2016. You can access the papers at nam.edu/Perspectives and sign up to the Perspectives listserv at nam.edu/ListservSignUp. To watch the full recording of the May 11, 2015 meeting, please visit nam.edu/SocialJustice. A group of external peer reviewers reviewed the papers. They included: **Brigadier General Clara L. Adams-Ender**, United States Army Nurse Corps (retired), **David Brent, MD**, University of Pittsburgh, **David Britt, MPA**, Sesame Workshop (retired), **Hernan Cervante, BS**, Vera Institute of Justice, **Mark Courtney, PhD**, University of Chicago, **Elena Fuentes Afflick, MD**, University of California, San Francisco, **Amy Griffin**, National Institute of Justice, **Harry Holzer, PhD**, Georgetown University, **Larke Huang, PhD**, Substance Abuse and Mental Health Services Administration, **Jeff Hutchinson, MD**, Uniformed Services University of the Health Sciences, **Ann Masten, PhD**, University of Minnesota, **Christine Ramey, MBA, BSN, RN**, Health Resources and Services Administration, and member of the Academies' Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, **Martin Sepulveda, MD, MPH, IBM**, **Melissa Simon, MD**, Northwestern University Feinberg School of Medicine, and member of the Academies' Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, **Belinda Sims, PhD**, National Institute on Drug Abuse, and **Mildred Thompson, MSW**, PolicyLink Center for Health Equity and Place, and former member of the Academies' Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

Notes

1. RCMI Multidisciplinary And Translational Research Infrastructure eXpansion (RMATRIX) is funded by the National Institute on Minority Health and Health Disparities, National Institutes of Health (2U54MD007584-04).
2. The PILI 'Ohana Program has been funded by the National Institute on Minority Health and Health Disparities (R24MD001660) and the National Cancer Institute (U54 CA153459) of the National Institutes of Health. Pili is also a Hawaiian word meaning "joining together" and 'ohana is Hawaiian for "family."
3. The HELA Project was also funded by NIMHD through RMATRIX-I (U54MD007584). Hela is also a Hawaiian word referring to a type of hula movement.

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Suggested Citation

Mokuau, N., P.H. DeLeon, J.K. Kaholokula, S. Soares, J.U. Tsark, and C. Haia. 2016. *Challenges and Promise of Health Equity for Native Hawaiians*. Discussion Paper, National Academy of Medicine, Washington, DC. <https://nam.edu/wp-content/uploads/2016/10/Challenges-and-Promise-of-Health-Equity-for-Native-Hawaiians.pdf>

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Acknowledgements

The authors would like to acknowledge Ms. Theresa Kreif, Assistant to the Dean, Myron B. Thompson School of Social Work, University of Hawaii at Mānoa.

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