June/July 2000

Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

Federal Officials Organize to Address Unique Health Needs of Pacific Islanders

By Houkje Ross

Robert Underwood, Guam's non-voting delegate in the U.S. House of Representatives, believes that the needs of Pacific Islanders are too often overlooked by public and private policymakers, program managers, educators, and researchers.

Speaking May 9 before the Interagency Working Group (IWG) of the White House Initiative on Asian Americans and Pacific Islanders (AAPI), Underwood said, "We could hold an entire oversight hearing on all the times Pacific Islanders have been overlooked." Underwood cited *Reaching the Top*, the College Board's 1999 report on higher education and minorities, as a case in point. "Pacific Islanders and Southeast Asians were not even included in the report," he said.

Federal officials and community representatives hope that the year-old White House Initiative will help direct attention and resources to the health, education, and social service needs of Pacific Islanders, as well as Native Hawaiians and Asian Americans. President Clinton issued Executive Order 13125 on June 7, 1999, creating the Initiative specifically to increase the participation of Asian Americans and Pacific Islanders in federal programs.

"I am committed to ensuring that Pacific Islander and Native Hawaiian community groups in the continental U.S., Hawai'i, and in the U.S.-associated Pacific Island jurisdictions are at the table as full partners in all of our Initiative activities," said Shamina Singh, executive director of the White House Initiative. "There are numerous disparities faced by Asian Americans and Pacific Islanders that must be addressed."

The executive order also established the President's Advisory Commission on AAPIs (see p.2) and the IWG, which comprises officials throughout the federal government, and is chaired by Department of Health and Human Services Deputy Secretary Kevin Thurm.

Getting community feedback

Commission members plan to hold town hall meetings in California, New York, the Midwest, and Hawaii. According to Charmaine Manansala, senior policy analyst for the White House Initiative, getting feedback from Pacific Islanders and those who work with the population is an effective way to evaluate the needs.

At the May 2000 IWG meeting, Marie Ma'o, director of human and social services for American Samoa, described some of the challenges she faces in her work. "Grant applications for programs like Women, Infants, and Children are often very complicated," Ma'o said. "If I have a question, I have to talk with a different person every time, which is time consuming."

Pacific Islanders who receive services through federal government programs also face language and cultural barriers. "Our family is the foundation of our culture. Services that you bring often don't make sense to us unless they serve the entire family," Ma'o said.

Ma'o used the example of having to translate a brochure that gave parents advice on how to deal with child abuse issues. The brochure contained the phrase "Respect your child." According to Ma'o, "Many families ended up throwing out the brochure because in the Samoan culture, the word respect is reserved for elders and leaders. In our culture, it didn't make sense for parents to be reading about respect for children. So we had to change the words to 'love your children;' that is something parents could understand."

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OFFICE OF PUBLIC HEALTH AND SCIENCE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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June/July 2000

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The editors of Closing the Gap would like to thank Stephen P. Jiang, Hawaii State Department of Health, and Dr. Pua'ala'okalani Aiu, of Papa Ola Lokahi, Honolulu, for bringing this issue to life

Inside

Unique Needs...*from page 1*

Surveying federal agencies

In July, the IWG plans to complete a federal inventory of AAPI participation in major federal programs during 1999. Representatives from 32 federal agencies, including the Departments of Defense, Commerce, Energy, and Education, will report projects and initiatives designed specifically for AAPIs. They will also document current employment levels of AAPIs in the federal government. IWG members will then advise HHS Secretary Donna E. Shalala on the implementation and coordination of these federal programs.

Barbara Chow, associate director of the Office of Management and Budget (OMB), underscored the importance of this analysis. "These numbers hold an enormous amount of power," she said at the IWG meeting. "You can't do anything without the numbers." Chow noted that the Hispanic community felt underserved by Head Start programs for many years, but it wasn't until documentation and data were compiled that the federal government set goals to increase Hispanic participation in the program.

According to Sen. Daniel Akaka (D-HI), HHS is the only federal agency that has established a policy to implement OMB's newly revised standards for classifying race and ethnicity in government statistics. He strongly encouraged other agencies to implement the directive.

"Data collection and statistics for Pacific Islanders can best be described as dismal and inadequate," said Sen. Akaka. He and others are concerned that the larger numbers of Asian Americans make it harder to understand what the data might show about Pacific Islanders, who face different circumstances and challenges than Asian Americans. To many, the recent change to OMB standards—making it mandatory for federal data collectors to separate out data on Native Hawaiians and other Pacific Islander groups from Asian American data—is a step in the right direction.

For more information on the White House Initiative on AAPIs, visit: www.hrsa.gov/aapi; or call (301) 443-2492. ❖

President's Advisory Commission on AAPIs

The Presidential Commission on AAPIs, consists of 15 representatives from the AAPI community who will advise the President on actions needed to improve the lives of AAPIs.

Chair: The Honorable Norman Y. Mineta. Edgewater, MD. Nominee for U.S. Secretary of Commerce, and former member of U.S. House of Representatives. Vice President, Special Business Initiatives, Lockheed Martin.

Ms. Haunani Apoliona. Honolulu, HI. Trustee of the Office of Hawaiian Affairs for the State of Hawaii.

Ms. Gloria Caoile. Springfield, VA. Special Assistant to the President, American Federation of State, County and Municipal Employees, and Vice President of the National Asian Pacific American Labor Alliance.

Ms. Martha Choe. Seattle, WA. Director, Department of Community, Trade and Economic Development, Washington state.

Ms. Susan Soon-Keum Cox. Eugene, OR. Expertise in the fields of international adoption and child welfare. Vice President of Public Policy and External Affairs, Holt International Child Services.

Mr. Vinod Dham. Freemont, CA. Chairman, President, CEO, Silicon Spice, Inc., a communications technology development firm.

Dr. Wilfred P. Leon Guerrero. Asan, Guam. President and owner, WP Leon Guerrero & Associates consulting firm in Guam.

Ms. Tessie Guillermo. San Francisco, CA. Executive Director of the Asian and Pacific Islander American Health Forum.

Mr. Dennis Hayashi. Sacramento, CA. Director of the State of California Department of Fair Employment and Housing.

Dr. David D. Ho. Chappaqua, NY. A distinguished AIDS researcher who serves as the Director and CEO of the Aareon Diamond AIDS Research Center.

Ms. Ngoan Le. Chicago, IL. Deputy Commissioner of Human Services for Chicago.

Mr. Jonathon R. Leong. Piedmont, CA. Businessman and President of JLA Companies. Founder of Asian Business Association.

Mr. Mukesh Patel. Atlanta, Georgia. Leader in the hospitality industry. Founding member of the Asian American Hotel Owners Association.

Ms. Jacinta Folasa Titialii. Philadelphia, PA. Vice President and Assistant General Counsel for Tenet Healthcare Corp.

Mr. Lee Pao Xiong. St. Paul, MN. Director of Government and Community Relations for Concordia University. ❖

Closing Health Disparities in the U.S. Pacific Islands

Guest Editorial by Ferdinand Aranza, Director, Office of Insular Affairs, U.S. Department of the Interior

Hidden within the aggregate data customarily collected on AAPIs are numbers that reveal surprising lags in the health and well-being of people residing in the Pacific Basin. Higher infant mortality, lower life spans, higher fertility, and sky-high rates of diabetes and other chronic diseases among middle-aged adults are some of the indicators that fall on the shady side of the American norm. Others are rapid population growth, lower educational levels, depressed incomes, and double-digit unemployment. Infant mortality rates in American Samoa, for example, are almost twice as great as the U.S. average, while per capita income is less than one quarter the U.S. average.

For many Pacific Islanders, the road to health equity is strewn with potholes and obstacles. Those who live in American Samoa, the Commonwealth of the Northern Mariana Islands, and Guam know that their remoteness from Hawaii and the U.S. mainland creates enormous barriers that transcend geographic distance. Better access to health services and trained professionals, though extremely important, is only part of the solution.

For many Pacific Islanders, the road to health equity is strewn with potholes and obstacles.

To succeed, the goal of improved health for Pacific Islanders requires the creation of multifaceted opportunities in and outside the traditional realm of health care. It also entails a reorientation to issues that vary considerably from stateside experience, and the development of supportive policies to help overcome isolation.

Sustainable economic development is key. Pacific Islanders understand all too well that their livelihoods and well-being are extremely vulnerable to global environmental and economic forces that are beyond their control. Natural disasters often take a particularly heavy toll on their islands' finite resources and fragile ecosystems, and recovering from super typhoons and hurricanes takes years. Islands like Guam and the Northern Mariana Islands, for example, are within the "typhoon belt." It is not unusual for their communities to experience two or three typhoons a year, often with winds of over 100 m.p.h. Resources that would ordinarily go to supporting health care instead must be spent on rebuilding. Unresolved land use disputes and the negative effects of changes in foreign markets and terms of trade worsen the problem. Indeed, the impact seems disproportionately large in comparison to the small size of the islands.

In recognition of these and other compelling issues, President Clinton established the Interagency Group on Insular Affairs (IGIA) by Executive Memorandum on August 9, 1999. By so doing, he formalized a mechanism to bring together senior officials from throughout the federal government to work with the Secretary of the Interior, to clarify the concerns of American Samoa, the Commonwealth of the Northern Mariana Islands, and Guam, as well as those of their Caribbean counterpart, the U.S. Virgin Islands. The IGIA seeks to improve cross-cutting policy coordination, increase Federal responsiveness to insular area issues, and recommend policy and program remedies to the President.

As a first step the IGIA, in consultation with island leadership, has focused its attention on areas that promote sustainable growth consistent with the sound management of natural and fiscal resources, and on improving the general welfare of the islands to be on par with U.S. health, social, and economic indicators. The IGIA has also developed a comprehensive inventory of Federal regulatory, financial, and technical assistance programs for which the territories are eligible but do not now participate.

Issue clusters provide the IGIA with a roadmap for closer interdepartmental collaboration to address follow-up items, and lay out the framework for the work that remains. Broadly, these include economic planning and trade mission assistance, tax incentives, immigration and visa issues, job training assistance, budget and management controls, and new economic initiatives. The improvement of statistical capacity, land usage, solid and wastewater management, environmental hazard mitigation and clarification of disaster assistance round out the clusters.

Over the next few months, the IGIA will bring closure to as many of these issues as possible by engaging insular area representatives in discussions and negotiations with federal officials. It will not be alone in that effort. The IGIA's work to create a supportive and effective policy environment for the Pacific insular areas, is fully complemented by the White House Initiative on Asian Americans and Pacific Islanders. These two interlinked groups create a synergy that will forward the health agenda of Pacific Islanders. Working together, these groups can ensure that health-making opportunities not only exist temporarily, but are created for many years to come.

For more information on the IGIA, visit the Office of Insular Affairs Web site: http://www.doi.gov/oia.❖

Correcting the Visions of Paradise

By Stephen P. Jiang, ACSW

Hawai'i. The word alone conjures thoughts of beautiful beaches, aqua blue waters, and warm sunny days. The nation's only island state, 2500 miles southwest of California, is the most remote land mass in the world. Typically, visitors vacationing in Hawai'i take home memories of resort locales such as Waikiki, Lahaina, or Kona. Visions of Hawai'i created by media images and television shows such as Baywatch Hawai'i perpetuate these stereotypes.

What most visitors do not realize is that Hawai'i is a rural state. Nearly 90 percent of the state's land mass with 20 percent of the state's population is federally designated as rural. The remaining 80 percent of the state's population reside on the island of O'ahu, where Honolulu, the state's only urban center, is located.

All seven of Hawai'i's other islands are rural. These communities face many problems common to all rural areas, with the additional challenges of allocating resources to distinct island populations.

Misconceptions about Hawai'i tend to blind policymakers to the state's health issues, especially challenges faced by Hawai'i's rural residents. "We have to get policymakers to realize that they cannot think of Hawai'i based on their last vacation. The state's rural health issues are real and unique," said Kirk Lange, health planner in the Hawai'i State Office of Rural Health (SORH).

Ethnic Makeup in Hawai'i

Total population of Hawai'i was 1,248,807 in 1998. Hawaii's Department of Health break down its population in 1998 is:

Ethnicity	Number of People	Percent
Unmixed (except Hawaiian)	688,747	60%
Caucasian	252,320	22%
Black	17,433	1.5%
Japanese	208,653	18%
Chinese	41,843	4%
Filipino	146,380	12.7%
Korean	13,728	1.2%
Samoan/Tongan	8,390	>1.0%
Mixed (except Hawaiian)	223,595	18%
Hawaiian/Part Hawaiian	236,465	19%

Health care resource allocation represents one such problem. While a significant number of residents live in rural Hawai'i, the state's health care resources are concentrated primarily in Honolulu. As a result of the imbalance of resource allocation, six of the of the state's eight primary care health professions shortage areas (HPSA), all seven of its dental HPSAs, and all of its four mental health HPSAs are on neighbor islands.

Access to adequate care is made more difficult on the neighbor islands because the only means of transportation between islands is by plane. "Neighbor island residents traveling to Honolulu in search of care typically spend $100 for round trip airfare, ground transportation and maybe lodging," according to Valerie Yin, director of the SORH. Furthermore, there are no reliable means of public transportation on neighbor islands, so even access to local care is difficult.

Transportation issues and isolation also make it hard to attract and retain health professionals in rural Hawai'i. As in other rural states, most health professionals choose to live and practice in urban areas rather than in rural communities.

While Hawai'i has long enjoyed a reputation as a state with many positive health status indicators, the state still faces a number of health issues. The rates of suicide, hepatitis A and C, measles, mumps, rubella, chronic and binge drinking, cancer, diabetes, and obesity are examples of key health status indicators that are worse in Hawai'i than the U.S. average. In most cases, Native Hawaiians and other Pacific Islanders have the worst health indicators in the state. Of special concern, Hawai'i has the worst tuberculosis indicators in the nation.

Hawai'i's poor economic health has exacerbated its health needs. While the economy has been surging in the continental U.S., Hawai'i is still struggling. During the 1990s, agriculture, tourism, and military support, the three pillars of Hawai'i's economy, were all negatively impacted by downturns in the American and Asian economies. Hawai'i's rural hospitals have been hurt financially by the state's economic downturn, as well as by cuts in federal reimbursements mandated by the Balanced Budget Act of 1997. Heightened unemployment and underemployment have reduced coverage by Hawai'i's much touted employer mandate for health insurance coverage.

SORH is meeting these unique rural island needs through a number of efforts. SORH is implementing the Critical Access Hospital program to help maintain access to hospital care in rural areas. To build community-based economic development capacity, SORH is undertaking efforts to replicate the federal Office of Rural Health Policy/ USDA Operation Rural Health Works project. All of these efforts are being directed by a statewide comprehensive rural health plan, currently being developed in partnership with the state's dynamic rural health association.

SORH is also working with the Hawai'i State Primary Care Association, the State Primary Care Office, and Hawai'i's Area Health Education Centers to remedy health professional shortage problems through various recruitment and retention efforts. Key programs include the Native Hawaiian Health Scholarship Program (NHHSP), the J–1 visa waiver program, and the National Health Service Corps. The NHHSP is designed to recruit Native Hawaiian students who are required to serve in predominantly Native Hawaiian communities.

Yin concludes that raising education and awareness about rural health issues is also a critical part of her office's plans. "People whose perception of Hawai'i is based on media mistakenly assume all is well in Hawai'i. A great deal of education has to be conducted to eliminate the stereotypes that divert attention from the health care needs in Hawai'i in general, and rural Hawai'i in particular," she said.

For more information, contact SORH at 808-586-4188.

Mr. Jiang is a Planner for the State Office of Rural Health, Hawai'i State Department of Health. ❖

Health Disparities Among Pacific Islanders

By Neal A. Palafox, MD, MPH, and Momi Kaanoi, MD

The United States took responsibility for the health, education, and welfare of the people of three Pacific Island jurisdictions under a United Nations Trusteeship in 1947. Samoa and Guam were already U.S. territories at that time. Although the trust jurisdictions have subsequently become Independent Nations, with Compacts of Free Association with the United States, their health and welfare is still dependent on the U.S. The United States has a responsibility to ensure that it honors its historical relationship to these Nations and territories.

The health systems subsequently instituted in these jurisdictions were modeled after the United States health system. These systems tended to be hospital based with little emphasis on prevention or public health. Presently, a large disparity in health status exists between these six jurisdictions and the United States as a whole. There are also large health disparities between jurisdictions.

The disparity in health between the U.S. and its associated Pacific jurisdictions can best be understood by examining some of the common health indicators, as well as the Healthy People 2010 Objectives. Tobacco is one example.

Tobacco use in the Pacific

The first barrier to effective health care is the paucity of health data. Healthy People 2010 has baseline measures for Hawaiians and Pacific Islanders (NHPI) for only 1 of 18 applicable objectives related to tobacco use.

According the HP2010, 21 percent of NHPIs 18 and older smoke. This makes NHPI's the second least likely ethnic group to smoke. American Indians and Alaska Natives (34 percent) are the most likely to smoke.

However, using local data we can see that almost all groups of Samoans and Guamanians have higher smoking rates than cited in HP2010. While the data are not necessarily comparable, the discrepancies highlight some of the frustrations of planning appropriate prevention programs, and of getting federal attention for health programs in the Pacific.

Despite rising trends in cigarette use, there are few appropriate tobacco prevention programs due to geographic distance, a lack of culturally appropriate models for the Pacific, and multiple health crises occurring simultaneously. Tobacco advertising is resource-rich, agressive, and uses established cultural norms (linking tobacco to betelnut use). Recent cigarette advertising campaigns have included free tee-shirts in exchange for 15 empty cigarette packs, cash sweepstakes with a grand prize of $1,000 in Truk and FSM; and cash prize raffles of $10,000 in the RMI.

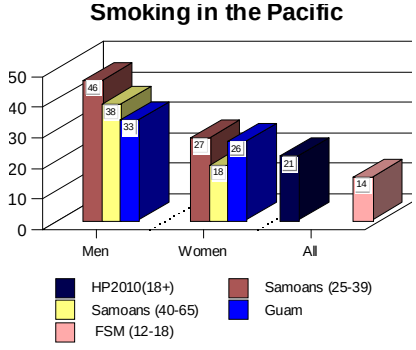
The Pacific compact nations suffer many of the ills of American society, without the benefits of access to first world health care. The data reveal that the compact nations tend to have poorer health statistics than the Flag territories, who generally have access to more resources than their neighbors. America cannot turn its back on the health of these fledgling nations whose current state is due, in part, to our own carelessness.

Dr. Palafox is co-chair of the Department of Family Medicine and Community Health at the John A. Burns School of Medicine, University of Hawai'i. Dr. Ka'anoi is a faculty development fellow with the JABSCOM family practice residency program and the Native Hawaiian Center of Excellence.❖

The U.S.-Associated Pacific

The U.S. Associated Pacific consists of three Flag Territories and three Freely Associated States, each with its own distinct language, culture, history and politico-economic development.

- The "Flag Territories" are:
  - American Samoa
  - Territory of Guam
  - The Commonwealth of the Northern Mariana Islands (CNMI)
- The Freely Associated States are:
  - Federated States of Micronesia (FSM): Truk (Chuuk), Kosrae, Pohnpei, Yap
  - Republic of Palau (ROP)
  - Republic of the Marshall Islands (RMI)



Other Health Disparities*

Life Expectancy at Birth	
US	76.1 yrs
Guam	74.0 yrs
CNMI	72.8 yrs
American Samoa	71.6 yrs
ROP	67.0 yrs
FSM	67.0 yrs
RMI	64.2 yrs
Infant Deaths per 1000 live Births	
US	7.2
Guam	8.9
CNMI	9.3
American Samoa	13.0
ROP	26.0
RMI	26.7
FSM	46.0
Fertility Rates per woman	
Guam	2.0
US	2.1
Guam	2.2
ROP	2.7
FSM	3.9
American Samoa	4.2
RMI	6.8
Children Under 2 fully Immunized	
ROP	92.4
FSM	84.1
US	75.0
American Samoa	72.0
Guam	70.0
CNMI	56.4
RMI	54.4
Health Care Expenditures Per Capita	
ROP	$633
Guam	$510
RMI	$128
Yap	$178
FSM	$132
Pohnpei	$143
Kosrae	$151
Truk (Chuuk)	$ 92

**Source: Institute of Medicine Pacific Partnerships for Health Report, 1998.*

Inouye Amendments Would Extend the Native Hawaiian Health Care Act

By Houkje Ross

Seeking to extend health care services to more Native Hawaiians and promote health care practices in tune with their traditional culture, Sen. Daniel Inouye (D-HI) proposed amendments to the law that authorizes funds for health care services directed to the Native Hawaiian population.

Introduced in November, Sen. Inouye's bill, S. 1929, the Native Hawaiian Health Care Improvement Act Reauthorization of 1999, also would extend the authorization of appropriations for Native Hawaiian health programs from 2002 to 2011, and would support research on the feasibility of making health care an entitlement for Native Hawaiians.

Extended in 1988 and reauthorized in 1992, the Native Hawaiian Health Care Act funds five health service organizations in Hawaii that provide: health promotion and education classes; disease prevention through screening, monitoring, case management, exercise, nutrition, and alternative therapies; and referrals to social services and primary care.

The Act also provides funds for a Native Hawaiian Health Professions Scholarship Program, which aims to improve access to health services by increasing the number of Native Hawaiians in the health professions.

Papa Ola Lokahi is the umbrella agency that administers funds and services. It work s with the five health centers and plans, provides training and technical assistance, supports research, and serves as a clearinghouse for data and information.

Integrating Traditional Cultural Practices

Sen. Inouye's proposed modifications of the law represent "fine tuning" of the existing legislation said Hardy Spoehr, executive director of Papa Ola Lokahi.

"There is a great desire by the local community to see a return to traditional healing practices," Spoehr said. These include the use of herbal medicines (laʻau lapaʻau), body manipulation or massage (lomilomi), and mental health or problem solving in the family (hoʻoponopono), he said.

"In the last 30 years, the Native Hawaiian community has really begun to feel the stresses and pressures of changes brought about by economic development," said Spoehr. As more land becomes developed, there is more concrete and less farming, and less consumption of healthy foods, according to Spoehr.

In 1998, Papa Ola Lokahi held a Health Summit in which Native Hawaiians discussed and developed health goals and objectives for their communities. Approximately 800 people attended the summit, many more than were expected, said Spoehr. People from all sections of the community attended: the employed, the unemployed, young, old, professionals, non-professionals. One of the most significant contributions the community made to the bill was the addition of culturally competent health care for Native Hawaiians.

"The amended bill incorporates the desires of local communities to return to lives that are based on the natural environment, the land and the sea," said Spoehr. It calls for increasing the number of culturally competent health care workers; increasing the use of traditional Native Hawaiian foods in peoples' diets and dietary preferences; and identifying and instituting Native Hawaiian cultural values and practices within the "corporate cultures" of organizations and agencies providing health service to Native Hawaiians. Amendments would also call for the use of Native Hawaiian healing practices by healers; and support training and education activities and programs in traditional Native Hawaiian healing practices by Native Hawaiian healers.

"The amended bill incorporates the desires of local communities to return to lives that are based on the natural environment, the land and the sea."

Other amendments would provide for the establishment of additional health care systems to serve the islands of Lanaʻi and Niʻihau. The revised bill would also authorize Papa Ola Lokahi to carry out Native Hawaiian demonstration projects in areas such as education of health professionals. It would call for the development of a centralized database and information system on the health care status, needs, and wellness of Native Hawaiians. Other projects would include:

- Integration of Western medicine with complementary health practices, including traditional Native Hawaiian healing practices;
- Use of tele-wellness and telecommunications in chronic disease management, health promotion, and disease prevention; and
- Establishment of a Native Hawaiian Center of Excellence for nursing, mental health and nutrition, and research, training, and integrated medicine.

For more information on the Native Hawaiian Health Care Act and the proposed amendments, contact: Senator Daniel Inouye's office, (202) 224-3934, or visit http://www.senate.gov/~inouye/ To contact Papa Ola Lokahi, call (808) 536-9453.❖

New Federal Standards Recognize Native Hawaiians and Other Pacific Islanders as Distinct Group

By Houkje Ross

If you are a Native Hawaiian or Pacific Islander, you probably noticed the change on the Census 2000 form. While previous Census forms grouped Native Hawaiians and other Pacific Islanders with Asian Americans, there is now a separate category called "Native Hawaiian or Other Pacific Islander."

This change is one of the most visible results of the 1997 "Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity." Promulgated by the Office of Management and Budget (OMB), this guidance is the revision of OMB Statistical Directive 15 (OMB 15). The directive aims to make the collection and use of data on race and ethnicity by federal agencies uniform. The five categories for race are: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; and White. The two categories for ethnicity are: "Hispanic or Latino" and "Not Hispanic or Latino."

Growth of interracial marriages and an increase in immigration stimulated the revision to OMB-15. There was also a letter writing campaign by Native Hawaiians and Pacific Islander communities who wanted to be counted separately from Asians, according to Olivia Carter-Pokras, PhD, director of the Office of Minority Health's Division of Policy and Data.

According to Puaʻalaʻokalani Aiu, PhD, of the Hawaiian health organization Papa Ola Lokahi, implementing the OMB revisions will help solve one problem affecting researchers and program managers. "Combining data on the larger Asian American populations with several, much smaller Pacific Islander populations tends to conceal substantial differences in health status and needs among these groups," she said. "When that happens, program planning for Native Hawaiians and Pacific Islanders suffers."

In 1997 Asian American and Pacific Islanders (AAPI) populations accounted for approximately 10.4 million people or 4 percent of the total U.S. population, according to the U.S. Census Bureau. Pacific Islanders comprised approximately 5 percent of the AAPI population.

Jeffrey Caballero, executive director of the Association of Asian Pacific Community Health Organizations (AAPCHO), added, "The revisions will enable us to validate the trends we have seen in small scale studies and give us a more detailed picture of the Pacific Islander community."

Who are Pacific Islanders?

- Polynesians: Native Hawaiians, Samoans, and Tongans, Maoris, Cook Islanders, Tahitians, and Rapa Nui.
- Micronesians: Marshall Islanders, Palauans, Chamorros, Northern Mariana Islanders, and Carolinians
- Melanesians: Fijians

The original guidance laid out the minimum for what data collectors needed to do, according to Dr. Carter-Pokras. "But many data systems did not go further. The separate category will make it more likely that data will be presented for Native Hawaiians and other Pacific Islanders. Then we should be able to monitor the health trends of Pacific Islanders with more accuracy," she said.

The 1997 revisions also include the following changes:

- Encourages data collectors to ask two separate questions for race and ethnicity. OMB-15 allowed data collectors to collect and report information on race and ethnicity in two ways. They could ask two separate questions: "What is your race?" and "What is your ethnicity?" Or they could ask one question: What is your race *or* ethnicity? The new guidance allows for these same options but encourages data collectors to go with the two-question approach. "Studies show that asking two separate questions reduced missing information on Hispanic ethnicity and the use of "other race" by Hispanics," said Dr. Carter-Pokras. It also allowed more complete reporting of Hispanics.
- More than one option for race. OMB-15 had five basic categories by which individuals could identify themselves. These were: Black, White, Asian and Pacific Islander, Hispanic, and American Indian/Alaskan Native; you had to choose only one. The new guidance offers individuals the option of selecting more than one race. This ensures that federal agencies can maintain the ability to monitor compliance with civil rights laws. If an individual checks off two boxes, Pacific Islander and White, for example, the person is then classified as a minority and can be protected under civil rights laws.

This guidance applies to federal agencies, but federal officials hope that other institutions such as state governments and universities will follow this lead, according to Dr. Carter-Pokras.

For more information on the revised standards and implementation guidelines, click on "Statistical Policy" at: http://whitehouse.gov/OMB/inforeg. ❖

Comparing Native Hawaiians' Health to the Nation

By Pua'ala'okalani Aiu, PhD

As we head into the Pacific Century, it is a good time to pause and evaluate the health of those who populate the Pacific. This article looks at the health of Native Hawaiians as compared to the rest of the nation, using five of the Surgeon General's Leading Health Indicators for 2010, and one of the nutrition goals. Nutrition is not considered a leading indicator.

Unless otherwise noted, Native Hawaiian data for this article come from the 1998 State of Hawai'i Behavioral Risk Factor Survey (BRFS). Local data are not used in the Healthy People 2010 indicators, and therefore there are few baseline measures for Native Hawaiians (NH) or Other Pacific Islanders (PI). Federal agencies have only recently been required to collect separate statistics on Native Hawaiians and Pacific Islanders. All other data, including data on Asian Americans and Pacific Islanders (AAPI), are from Healthy People 2010.

Access to Health Care

Access to health care is a major issue across America, as fewer employers offer health care coverage to their employees (Commonwealth Fund). As the only state with an ERISA waiver, which requires employers to offer health benefits to employees working 20 hours a week or more, Hawai'i tends to have lower numbers of uninsured than other states. However, certain pockets of the population, Native Hawaiians among them, tend to be both unemployed and uninsured.

HP 2010 Access Objective 1.1.: Increase the proportion of persons with health insurance.

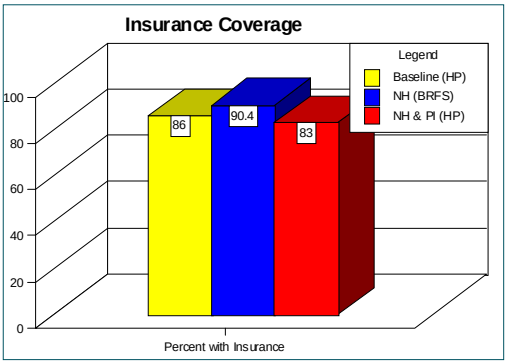
Target: 100 Percent.

Baseline: 86 percent 1997 (age adjusted to the year 2000 standard population).

Native Hawaiians and other Pacific Islanders: 83 percent (NHIS, CDC, NCHS, Nov. 1999).

Native Hawaiians: 90.4 percent (BRFS 1998).

As the graph shows, Native Hawaiians in Hawai'i have higher numbers of insured than the nation. Compared to other ethnic groups in the state, Native Hawaiians have the lowest percentage of people insured. People of Japanese ancestry have the highest rates of insurance coverage (98.5 percent insured), while 93 percent of the Caucasian population is insured.

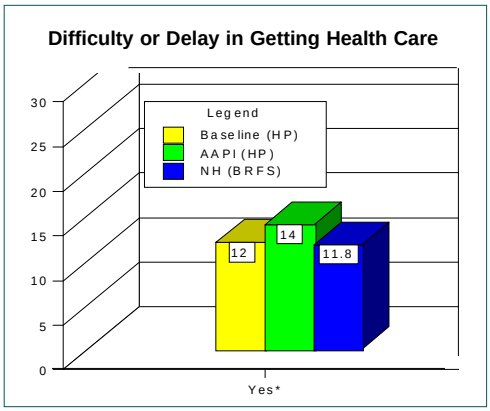


In addition, access can be difficult for people in rural areas, single mothers with children, the elderly, and people without transportation. The 1985 E Ola Mau study showed Native Hawaiians had disproportionately poor health compared to other ethnic groups in the state. In 1988, the U.S. enacted the Native Hawaiian Health Care Act, which created systems to ensure increased access to care for Native Hawaiians (see p. 6).

HP2010 Access Objective 1.6.: Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members.

Target: 7 percent.

Baseline: 12 percent of families experienced difficulties or delays in obtaining health care or did not receive needed health care in 1996.



When asked if cost was a barrier to health care in the past year, 11 percent of Native Hawaiians in the 1998 BRFS study cited cost as a barrier. Other barriers were child care and transportation.

Overweight and Obesity

Almost half of all Americans and 30 percent of children are overweight. Native Hawaiians tend to be the most overweight among all ethnic populations in Hawai'i. Almost 50 percent of Native Hawaiians are obese.

Overweight and Obesity Objective 19.2.: Reduce the proportion of adults who are obese.

Target: 15 percent.

Baseline: 23 percent of adults aged 20 years and older where identitified as obese, with a Body Mass Index (BMI) of 30 or more in 1988–94 (age adjusted to the year 2000 standard population).

Overweight: BMI greater than 27.3 for females, and greater than 27.8 for males. The chart also shows the percentage of Native Hawaiians who are over 120 percent of the median weight for state residents.

The data in this chart are not really comparable, although they can give one some idea of a comparison betweeen groups. In Hawai'i, which is known as the health state, Native Hawaiians have the highest percentage of obese people (49 percent).

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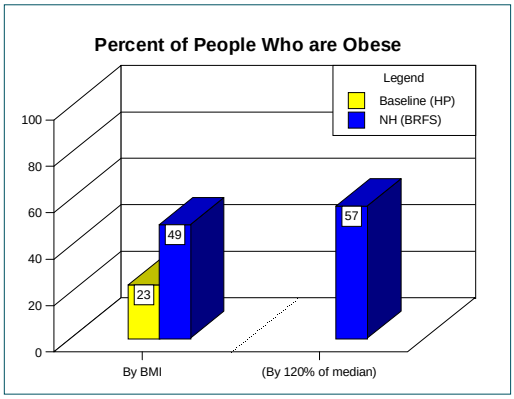


Nutrition

Although nutrition is not a leading indicator, obesity and nutrition are tied together, and have a great impact on the lives of Native Hawaiians. The lack of proper nutrition contributes to obesity as well as other chronic diseases such as diabetes and cancer, both of which are high in Native Hawaiians (Tsark, 1995).

HP 2010 Nutrition Objective 19.5.: Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.
Target: 75 percent.
Baseline: 28 percent of persons aged 2 years and older consumed at least two daily servings of fruit in 1994-96 (age adjusted to year 2000 standard population).
AAPI: Data not available.
Native Hawaiians: 43 percent answered "daily or more" to the question, "Not counting juice, how often do you eat fruit?"

The two categories are not really comparable because the HP2010 asks about two servings daily and the BRFSS asks if fruit is consumed at least once a day.

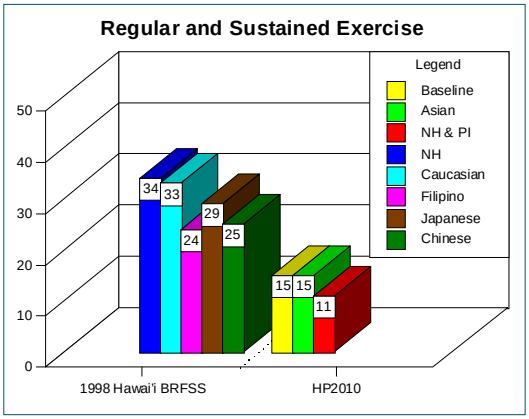
Although Native Hawaiians seem to consume more fruits than the average American, both groups are well below the target. Native Hawaiians eat less fruit than any other ethnic group in Hawai'i.

Physical Activity

Along with good nutrition, physical activity leads to better health. Americans, on the average, do not get enough exercise. In Hawai'i, Native Hawaiians have always been less sedentary than other ethnic groups, while still being more obese.

HP2010 Physical Activity Objective 22.2.: Increase the proporiton of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.
Target: 30 percent.
Baseline: 15 percent of adults aged 18 and older were active for at least 30 minutes 5 or more days per week in 1997 (age adjusted to the year 2000 standard population).
Native Hawaiians: 29 percent of adults aged 18 years and older engaged in regular physical activity for 30 minutes 5 or more days per week in 1998, regardless of intensity.

All ethnic groups in Hawai'i report more physical activity than the national indicators.

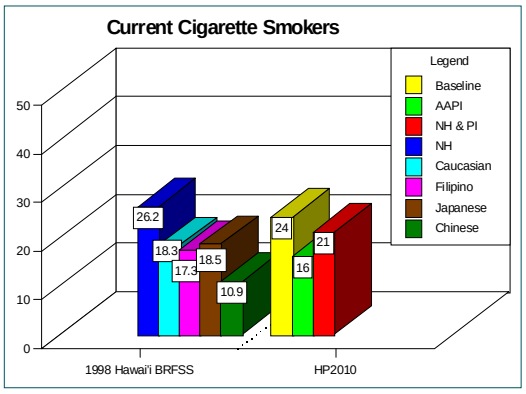


Several ethnic groups in Hawai'i, including Native Hawaiians, exceed or are approaching the HP2010 goal of 30 percent of adults engaging in regular physical activity.

Tobacco Use

HP2010 Tobacco Use Objective 27.1.: Reduce Tobacco use by Adults.
Cigarette Smoking
Target:12 percent.
Baseline: 24 percent (Age adjusted to 2000 population standard).
Native Hawaiians: 26 percent.

More Native Hawaiians are smokers than the national norm, and only Native Americans report a higher level of current smokers (HP2010). Native Hawaiians also smoke more than any other ethnic group in Hawai'i.

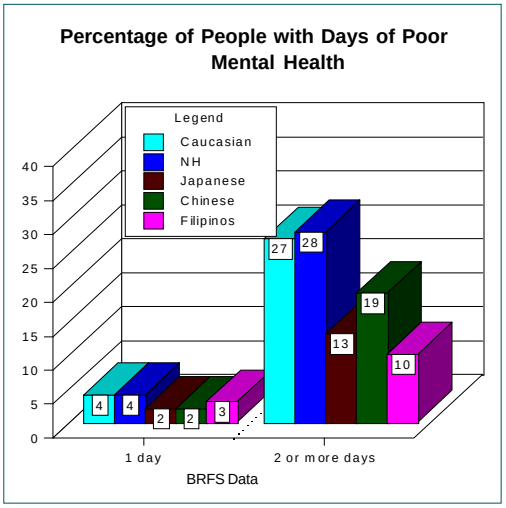


Mental Health

HP 2010 Goal: Improve mental health services and ensure access to appropriate quality mental health services.

HP 2010 has 14 objectives for mental health, although none are closely comparable to the BRFS data from Hawaii reported below. HP 2010 notes that population group data, including Native Hawaiian and Pacific Islander data, were not collected, not analyzed, or statistically unreliable for most objectives. Only one objective even has a combined API baseline. The difficulty in quantifying poor mental health adds to the difficulty in measuring advances or declines in this area.

Dr. Aiu is Program Evaluation and Data Development Officer, Papa Ola Lokahi, Honolulu. For more information, call (808) 536-9453. ❖

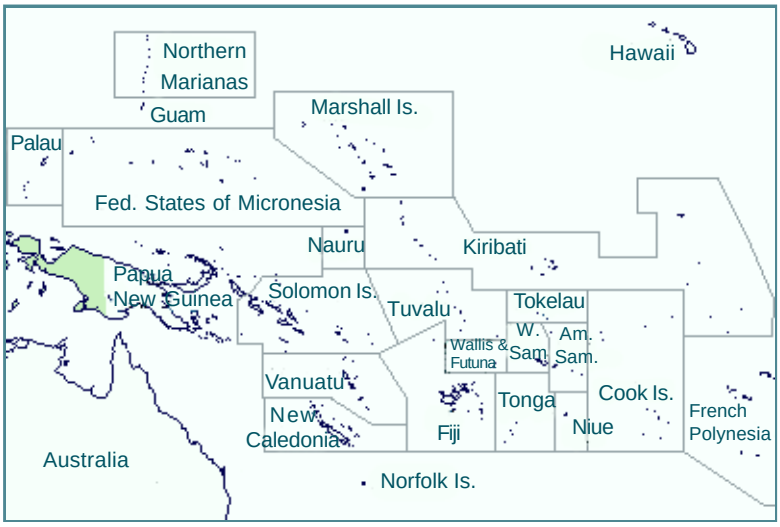


Connecting Pacific Islands to Specialty Care

By Houkje Ross

Residents of the U.S.-associated Pacific jurisdictions live on 104 islands covering an area larger than the continental U.S. Health professionals are in short supply. Hospital care often requires travel by plane or boat. Patients needing specialty care may be referred as far away as the Philippines or Hawaii. In American Samoa, 30 percent of the total health budget is devoted to off-island referrals. It is no wonder that Pacific jurisdictions are vitally interested in the promise of telemedicine and telehealth.

Medical and health care practices enhanced by the use of telecommunications and computer technologies—including digital cameras, video and audio transmission, and the Internet—can help link physicians in the Pacific jurisdictions to colleagues in Hawaii. They can also link health care workers on outlying islands to the hospital or health department in their own country or territory.



In an effort to use this technology to bring medical information, services and care to the region, the Health Resources and Services Administration (HRSA) launched the Pacific Basin Telehealth Initiative in 1999. The Republic of Palau and American Samoa are now testing two types of technology provided through HRSA's Office of the Advancement of Telehealth (OAT).

Testing New Telemedicine Possibilities

The Initiative chose America Samoa to test interactive teleconferencing equipment, which allows health care workers to see a specialist in Hawaii or elsewhere through a live video screen. "A wheelchair was ordered for a child on the Island, but by the time it arrived he had grown, so the chair had to be adjusted," said Cathy Wasem, director of Telemedicine-Telehealth Programs at OAT. "There was no one on the island who knew how to adjust the chair." Teleconferencing equipment allowed health care workers to see how a specialist in Hawaii was adjusting the wheelchair. "It was done on the spot," she said.

Most islands in the region have a shortage of health care professionals like nurses, pharmacists, radiologists, and laboratory technicians, according to Institute of Medicine's report, *Pacific Partnerships for Health*. Using telemedicine can save time, money, and lives. It can even be used in cases of emergencies. "For example, it can be used to stabilize a patient enough to be able to move him or her to a place that can provide the next level of care," said Wasem.

The second type of telemedicine being tested is store-and-forward technology, which captures audio or video clips of medical information and sends them to physicians off-island. Store-and-forward technology can be used to send medical images like X-rays, MRIs, or CAT scans to radiologists and other off-island specialists. Each jurisdiction has this type of technology provided by the Akamai project at Tripler Army Medical Center/PRPO. The HRSA initiative is hoping it can be used in new ways.

Traditionally the technology has connected physicians at the local hospital with specialists located at tertiary care centers. In Palau, the store-and-forward technologies are being piloted at the super-dispensaries, linking them to the republic's hospital and main clinic. In American Samoa, the interactive technologies are connecting the hospital with dispensaries on two outer islands—usually staffed with licensed nurse practitioners and emergency medical technicians. "This will enable 'front-line' health care workers to access the next level of care," said Wasem.

"In the future, we hope to be able to connect health care workers at dispensaries and other outlying clinics to continuing education classes and seminars," she added. Because there are no medical schools located in the jurisdictions, health care workers miss out on these opportunities. "Those involved in the Telemedicine Initiative in American Samoa are becoming excited about the educational possibilities," said Wasem. OAT also plans to develop Listservs for information sharing over the Internet.

The Initiative is also pulling together an inventory of existing telecommunication and telehealth resources in the region. A regional telehealth consortium, staffed by the University of Guam, is coordinating the inventory and expects to have it completed in 6–12 months. HRSA will also work with other federal agencies operating in the area to coordinate telehealth activities.

For more information on HRSA's Telehealth Initiative, contact Cathy Wasem, HRSA, (301) 443-0202.❖

AAPCHO, HRSA Address Health Disparities Among Pacific Islanders

By Daniel Toleran, Associate Director of Policy and Planning, Association of Asian Pacific Community Health Organizations

The Association of Asian Pacific Community Health Organizations (AAPCHO) and the Bureau of Primary Health Care (BPHC), Health Resources and Services and Administration (HRSA), recently took steps to respond to the primary health care issues and concerns of Pacific Islanders in the Pacific Basin.

As a result of discussions between these two organizations, a larger effort to identify and address the health disparities of Pacific Islanders is now underway, including an initiative to assess community-based care in the Pacific Basin and a conference to address the health concerns of this underserved area.

AAPCHO and HRSA's efforts occur alongside a renewed interest in Asian American and Pacific Islander (AAPI) concerns and issues—an interest that stemmed in part from national directives that were implemented as recently as last year, as well as the renegotiation process that is occurring between the U.S. and freely associated compact states.

The collaborative effort between AAPCHO and HRSA to address Pacific Islander primary care issues began last summer when Dr. Marilyn Gaston, director of BPHC/HRSA, asked AAPCHO to support the community health center (CHC) program in the Pacific Basin.

The project's objectives include:

- Obtaining input from Pacific Basin community-based organizations about current primary care and community health activities in their respective areas.
- Prioritizing the needs and issues for CHC programs in the Pacific Basin.
- Developing a strategic plan, as appropriate, to address community-based primary care services in the region.

Overall, AAPCHO supports the development of a primary care community infrastructure to address the health disparities of AAPIs in the Pacific Basin, as well as a coordinated response from the government in support of these local communities.

A meeting will be convened this year between key government officials, community stakeholders, AAPCHO, and its member agencies. Representatives from HRSA, BPHC, Region IX, the Pacific Island Health Officers Association (PIHOA), an associated state, a U.S. jurisdiction, and the Pacific Basin Medical Association, will determine the goals and objectives for the meeting.

AAPCHO hopes the meeting represents a firm step toward relationship building that is respectful of Pacific Islander people and their issues, and builds trust among those who have interest in the region.

The organization also hopes the meeting will lead to potential collaborations between AAPCHO and Pacific Basin representatives, such as meeting follow-up and/or participation in AAPCHO technical assistance services and other joint ventures.

AAPCHO is a national association representing community health organizations dedicated to improving the health status of Asian Americans, Native Hawaiians and Pacific Islanders in the U.S. and its territories. AAPCHO's mission will be accomplished by increasing the quality, accessibility and availability of comprehensive community based health care that is linguistically and culturally appropriate for these populations.

AAPCHO staffers Stacy Lavilla and Jeffrey Caballero contributed to this article.❖

The Pacific Substance Abuse and Mental Health Initiative

The Pacific Substance Abuse and Mental Health Initiative (PSAMHI) is an ongoing collaboration between the six Pacific Island jurisdictions, a technical assistance team, and officials of Substance Abuse and Mental Health Services Administration (SAMHSA). The National Asian Pacific American Families Against Substance Abuse (NAPAFASA) and the Office of Minority Health (OMH) provide administrative assistance. "It is important that programs are in place before mental health and substance abuse problems become too big to adequately address," said Ford Kuramoto, Executive Director of NAPAFASA.

"Lifesytle changes are taking their toll on the peoples of the Pacific," said Bruce Grant, SAMHSA project coordinator. "Consequently, we are seeing increasing substance abuse and mental health problems."

PSAMHI has three major goals:

1. Establish a professional certification process;
2. Prepare a cadre of substance abuse and mental health educators and trainers to meet community needs; and
3. Provide a forum for collaboration and resource sharing among participating jurisdictions.

The project has met most of its goals and its usefulness will extend beyond the life of the grant. The PSAMHI Collaborating Council, which has representatives from each participating government, will seek additional funding to expand its programs. The jurisdictions remain committed to funding staff to be part of the Council.

SAMHSA is also involved in an extensive, Pacific wide research project with the University of Hawai'i to study how changes in traditional lifestyles affect mental health and substance abuse in Pacific cultures. Five U.S.-Associated Pacific jurisdictions participate.

Through these projects, SAMHSA, OMH, and NAPAFASA would like to ensure that the Pacific not only remains on the agenda, but that the islands have the capacity to develop and sustain programs of their own design, suitable for their cultures.

For more information, call Dr. Grant at (301) 443-2387.❖

Diabetes Programs Have Local Style

By Jean Oxendine

When the Centers for Disease Control and Prevention's (CDC) Division of Diabetes Translation (DDT) launched the *Diabetes Today* program in 1991, they found that one size did not fit all.

The CDC's *Diabetes Today* National Training Center provides training programs for health care professionals and community leaders, who in turn can help local communities develop diabetes prevention initiatives. The goal is to empower those with diabetes, their families, health professionals, and others at the community level to work together to prevent and control diabetes.

But the national training wasn't working for Native Hawaiians and other Pacific Islanders. Cultural issues are a big factor, according to Betty Lamb, CDC's Project Officer for the *Pacific Diabetes Today* (PDT) program. "The people of the Pacific Region have unique historical and social experiences," she said. Another reason the national *Diabetes Today* program does not work in the Pacific was a lack of technical assistance and follow-up support for the region, said Audrey Ching, project manager for the PDT Resource Center.

A new and innovative public health approach for program development in the Pacific.

The Pacific Shapes Its Own Programs

Papa Ola Lokahi, a Native Hawaiian health consortium based in Honolulu, develops and maintains the regional *Diabetes Today* training consortium for CDC. The PDT program was designed to take into account the cultural differences found in Hawai'i and the Pacific region. "We have the same requirements as the other Diabetes Today program, but our style is different. We use existing community networks to convene groups to come and work together to plan activities that meet their particular geographic and cultural needs," said Ching.

The program works to engage communities affected by diabetes in describing the burden of diabetes in their community. The program also helps communities plan interventions to reduce risk factors and associated complications of diabetes. There are high rates of diabetes among Native Hawaiians and other Pacific Islanders. For example, approximately 30 percent of the population over age 15 suffer from Type II diabetes in the Marshall Islands, according to Lamb.

Papa Ola Lokahi assembled an advisory group called the Expert Council to provide leadership in formulating the Pacific version of *Diabetes Today*. The 15-member Council represents the five major Hawaiian islands and each Pacific jurisdiction—American Samoa, Guam, Republic of Palau, Republic of the Marshall Islands, Commonwealth of the Northern Mariana Islands, and the Federated States of Micronesia. Council members consist of secretaries of health, health directors of jurisdictions, physicians, nurses, researchers, community leaders, and clergy.

"The experts define appropriate community models for the region," said Lamb. They also establish and monitor each system and provide feedback to Papa Ola Lokahi on strategies to enhance the success of the training and community implementation programs, she added. Community groups are being encouraged by the CDC to design their own projects.

Developing the PDT program was especially challenging because a special curriculum is needed for the Pacific Basin to address the uniqueness of each group. This challenge is unique to Hawai'i and Pacific Island jurisdictions because residents speak different languages and within each language there may be different dialects. For most of these populations, English is not the first language. "Our cultures are very much oral cultures," said Ching. "We do not rely on the written language as the primary communication method—we are more comfortable sitting in circles learning from the sharing of stories.

"What works for Hawai'i does not necessarily work for all of the Pacific Islands, so we designed a project where each jurisdiction can develop programs that work for them," said Ching. "This program is a new and innovative public health approach for program development in the Pacific."

Papa Ola Lokahi conducted focus group interviews in American Samoa, Guam, Republic of Palau, Republic of the Marshall Islands, Commonwealth of the Northern Mariana islands, Federated States of Micronesia, and Hawai'i. The Expert Council oversaw the process and provided guidance.

The focus groups requested input from community members. They participated in evaluating the best ways to address diabetes in their communities. Questionnaires, handouts, and sample teaching materials were given to participants to solicit the best strategies for each community.

Materials were sometimes translated into the native language of the participants. "We can't translate all of the material, but we always have an on-site translator to assist in the process," said Ching. The vocabulary of written materials is often too complex, and PDT attempts to make it much easier by breaking down large words in to several shorter ones. For example, the words 'prevalence' and 'data' need to be broken down further to make sense with Pacific audiences.

As a result of the input gathered from focus groups, the curriculum will be revised and refined. The final curriculum will be completed by October 1. When each jurisdiction has its own PDT program in place, Papa Ola Lokahi will continue to provide technical assistance and support to the community sites.

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Pacific Island Health Officers Association

Dedicated to the health and well-being of Pacific Island populations, the Pacific Island Health Officers Association (PIHOA) serves as the unifying voice and credible authority on issues of regional significance. That mission is attained through collaborative efforts in capacity-building, advocacy, and policy development, to provide medical care, promote healthy lifestyles, prevent disease and injury, and protect the environment.

PIHOA was founded in 1986 in Honolulu, Hawai'i, as the regional health association representing the interests of the Territory of American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Territory of Guam, the Republic of the Marshall Islands, and the Republic of Palau.

PIHOA is a membership association and has been incorporated as a non-profit organization in the Commonwealth of the Northern Mariana Islands since 1987. The association is made up of the principal health officers of the six Pacific countries and territories affiliated with the United States.

Strategic priorities for 2001 to 2005

Collaborative activities and projects will be initiated with partners in the following:

- Environmental health
- Human resources development and management
- Health information systems and management
- Telemedicine and telehealth
- Chronic, non-communicable diseases (diabetes, hypertension, heart disease, etc.)
- Selected communicable diseases (tuberculosis and leprosy)

Sample areas of past and current work

- Developing a regional health policy.
- Capacity-building and strengthening Pacific Island health professional associations.
- Supporting and utilizing telecommunication technology for improved medical care.
- Controlling Hepatitis B and C, which includes sentinel disease surveillance and reporting.
- Developing and planning for the health workforce.
- Reviewing and analyzing medical referral costs.
- Publishing a health data matrix for the Pacific Islands.
- Publishing an email directory for the Pacific Islands.
- Providing technical assistance to members and coordinating with Federal agencies involved in the Pacific Islands.
- Supporting the Pacific maternal and child health program coordinators' meetings.
- Supporting regional oral health needs assessment.
- Supporting initiative for regional public health reference laboratory.
- Supporting computer and epidemiological training activities.

For more information, contact: Dr. Stephen Karel, PIHOA Executive Office, 1890 East West Road, Moore 427, School of Public Health, University of Hawai'i, Honolulu, HI 96822, (808) 956-6224, fax (808) 956-9512, e-mail: pihoa@hawaii.edu.❖

PIHOA Directors

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Secretary of Health
Commonwealth of the Northern Mariana Islands

Vice-President,
Dr. Joseph Tufa
Director of Health
American Samoa

Secretary,
Hon. Masao Ueda
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Federated States of Micronesia

Hon. Tadashi Lometo
Minister of Health and Environment
Republic of the Marshall Islands

Dennis Rodriquez
Director of Health
Guam

Diabetes Program...*from page 12*

A draft of the *Diabetes Today* curriculum was developed for each jurisdiction and Hawaii. Pilot testing took place in June in five sites—Pohnpei, Kosrae, Palau, Hawai'i and American Samoa. Each site identified community members to invite to the training. The planning efforts of these groups will be used to design and implement a plan for each community to address diabetes. Community leaders can then train others through local diabetes support groups to continue to increase awareness and participation on the community level. This will empower communities to develop community initiated action plans.

Papa Ola Lokahi will collect and analyze data to determine the relevance and cultural appropriateness of the PDT model for communities in the Pacific, according to Lamb. With the input from the jurisdictions, they will determine what is working and not working for each area and look at ways to make changes as necessary to best suit the people it aims to serve.

Within the first five years of the program, training, marketing and promotion, and evaluation plans will be developed. Training will take place throughout the Pacific region and Hawai'i. Technical assistance and follow-up visits will be conducted with the jurisdiction and Hawai'i PDT training sites.

For more information on the Pacific Diabetes Today program, contact Audrey Ching at Papa Ola Lokahi at (808)536-9453 or e-mail at audrey_ching@yahoo.com.❖

Serving Pacific Islanders in Southern California

By Houkje Ross

Last year, the Pacific Islander Community Council (PICC) asked local community health centers in Southern California to identify how many Pacific Islanders they serve. What PICC found is that many organizations confused Pacific Islanders with Asian Americans. "They came back with numbers for how many Filipinos and Pacific Rim Asians they served, but Filipinos are not Pacific Islanders," said Jane Ka'ala Pang, PICC's special projects chair.

"Few know about Pacific Islanders—our health practices, cultural values, beliefs, and most of all, our health crisis."

PICC, a grassroots organization in Carson, CA, was founded in 1991 to promote the cultural traditions, island practices, native languages, education, health, and welfare of all Pacific Islanders in Southern California. The Council represents Chamorros, Native Hawaiians, Samoans, Tongans, Tahitians, and other native Pacific Islanders from Polynesia, Melanesia, and Micronesia.

Pang said in the last few years, health has become a main priority. Recent PICC surveys reveal that Pacific Islanders in the area face barriers to care because of lack of insurance or financial support, language and cultural barriers, and transportation.

Pacific Islanders have also reported problems with diabetes, cancer, heart disease, high blood pressure, and stroke. As a result, PICC has expanded its services on health education and care. Twenty volunteer community members serve on the council, representing Pacific Islanders from Ventura to San Diego.

PICC meets monthly to plan an annual Pacific Islander festival, leadership development workshops, health screenings, and community assessment surveys. PICC and the 'Ainahau O Kaleponi Hawaiian Civic Club (HCC) have initiated several projects, addressing the importance of drug-free communities, senior nutritional centers, and breast cancer awareness.

PICC and HCC also joined together to hold a conference on Pacific Islander beliefs and health practices called, "Returning to Our Roots." Held in 1999, the conference brought together seniors, academics, nutrition students, and service providers, and emphasized the importance of traditional foods for Pacific Islanders.

The conference focused on how taro (karo), sweet potato ('uala), and breadfruit ('ulu) serve not only as a nutritional source, but as spiritual energy. "These roots are foods of the Gods," Pang said. HCC is working on a similar project focusing on traditional Hawaiian diet.

Upcoming PICC activities include partnering with health providers to ensure culturally and linguistically appropriate care. Through PICC, a small network of Pacific Islander health professionals will continue to volunteer at community events, educate the public, and provide health information and referral services to Pacific Islanders. "This will enable the community to gain a larger voice and become more recognized," Pang said.

For more information on PICC, contact Jane Pang, 714-968-1785. ❖

HRSA Develops Strategic Plan for Pacific Basin

By Houkje Ross

In February 2000 the Health Resources and Services Administration (HRSA) met with several other federal agencies and representatives from the six Pacific Basin jurisdictions to develop a strategic plan for improving health in the region.

The strategy involves creating better collaboration and communication with health ministers, health center administrators, medical staff and directors, and the community in the jurisdictions, said Paul Nannis, director of HRSA's Office of Planning, Evaluation, and Legislation.

"We are striving to listen to what the residents say they need," he added. "This is a very different approach from the past, which made the assumption that we, here in D.C., knew what the residents wanted."

HRSA's strategic plan is based on a 1998 report called *Pacific Partnerships for Health, Charting a New Course*. The non-partisan, Institute of Medicine (IOM), part of the National Academy of Sciences, produced the report for HRSA.

Some of the problems IOM identified include tuberculosis, Hansen's disease, lower life expectancies, and Vitamin A deficiencies due to poor diet. Even with federal funding, the residents of these islands are not as healthy as their mainland U.S. counterparts. Contributing factors, according to the IOM findings, are inadequate fiscal and personnel management systems, poorly maintained and equipped health care facilities, shortages of adequately trained health personnel, rapid economic development, and social changes.

Highlights from HRSA's strategic plan:

- Keeping other agencies informed. HRSA plans to establish a system to inform other offices, bureaus, and agencies about scheduled meetings and conferences with Pacific Basin representatives.
- Reducing the use of hospital-based acute care. Changing the region's dependence and overuse of hospital-based acute care is a significant element of the plan. According to the IOM report, there is not enough emphasis on public health and prevention programs.
- Recruiting health professionals to the Pacific Basin. HRSA administers the National Health Service Corps, which recruits medical school graduates to the Pacific Basin.

continued on page 15...

Resources

Asian and Pacific Islander American Health Forum, Inc.
942 Market Street, Suite 200
San Francisco, CA 94102
(415) 954-9988
http://www.apiahf.org

Asian and Pacific Islanders for Reproductive Health
310 8th Street, Suite 100
Oakland, CA 94607
(510) 268-8988
http://www.apirh.org

Association of Asian/Pacific Community Health Organizations
1440 Broadway, Suite 510
Oakland, CA 94612
(510) 272- 9536
http://www.aapcho.org

Asian Pacific Family Center
9353 East Valley Boulevard
Rosemead, Ca. 91770
(626) 287- 2988

Asian Pacific Health Care Venture, Inc.
1530 Hillhurst Ave., 2nd Floor
Los Angeles, Ca. 90027
(323) 644-3880
http://www.aphcv.org

Asian Pacific Resource Center
Montebello Library
1550 West Beverly Boulevard
Montebello, CA 90640
(323) 722-2650
http://www.colapublib.org/libs/montebello/asian.html

Center for Asians and Pacific Islanders
3702 East Lake Street
Suite 200
Minneapolis, MN 55406
(612) 721-0122
http://www.capiusa.org

Hawai'i State Department of Health
P.O. Box 3378
Hololulu, HI 96801-3378
(808) 586-4400
http://www.state.hi.us/health/index

Hawai'i Rural Health Association
3040 Umi Street
Lihue, HI 96766
(808) 241-3427
E-mail: mjsweene@mail.health.state.hi.us

Hawai'i STD/AIDS Prevention Program
Diamond Head Health Center
3627 Kilauea Ave., Suite 304
Honolulu, HI 96816
(808) 733-9281

National Asian Pacific American Families Against Substance Abuse (NAPAFASA)
340 East Second Strreet
Suite 409
Los Angeles, California 90012
(213) 625-5795
http://www.napafasa.org

National Asian Pacific Center on Aging
Melbourne Tower
1511 3rd Ave., Suite 914
Seattle, Washington 98101
(206) 624-1221
http://www.napca.org

Native Hawaiian Drug-Free Schools/Communities Program
1850 Makuakane Street, Building B
Honolulu, HI 96817
(808) 842-8508

Office of Hawaiian Affairs
711 Kapi'olani Blvd. Ste. 500
Honolulu, HI 96813
(808) 594-1888
http://www.oha.org
Produces the Native Hawaiian Databook, which is filled with statistics on population, housing, land, health, crime, education, income, etc.

Papa Ola Lokahi
222 Merchant Street, 2nd Floor
Honolulu, Hawaii 96813
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Strategies...*from page 14*

Graduates provide services in exchange for loan repayment. HRSA sponsored six graduates for work in the Pacific Basin in FY 1999, and continues to recruit others.

- Increasing funding for and use of telemedicine. This is important because there are not enough specialty physicians in the area. In the past, if a resident had symptoms that were not recognized, or a mid-level physician did not know how to treat something, the patient would be flown to another location. This takes up a huge portion of the hospital's budget, Nannis said. "Telemedicine would allow medical information and treatment options to be done over the Internet."
- Expanding primary care and maternal and child health initiatives. HRSA will work to improve, upgrade, and expand primary care and maternal and child health initiatives across the six jurisdictions, and support abstinence programs in the region. The agency will continue to support Maternal and Child Health Community Integrated Service System grants for each jurisdiction, along with Emergency Medical Systems for Children grants.

For more information, contact Paul Nannis, HRSA, 301-443-2460.❖

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Public Health and Science
Office of Minority Health Resource Center
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Closing the Gap

Conferences: Year 2000

July 26–28: Pacific Northwest Dental Conference. Washington State Conventon & Trade Center. Seattle, Washington. Sponsored by Washington State Dental Association. Contact: Amanda Tran (206) 448-1914. Or e-Mail: Amanda@wsda.org

Aug 10–17: Black Congress on Health, Law, and Economics*: Creating A Safe, Healthy, Drug-Free Environment.* Washington, DC. Contact: Derrick A. Humphries at the Black Congress on Health, Law, and Economics (202) 347-2800.

Sept 6-9: Fifth Annual Educational Conference and Exhibits. Orlando, Florida. Sponsored by the Society for Healthcare Strategy and Market Development, American Hospital Association. Call: (312) 422-3888 or e-mail: stratsos@aha.org

Sept 18–20: *Talking the Talk; Walking the Walk*. Sponsored by the Tennessee Governor's Council on Physical Health and Education. Adams' Mark Hotel. Memphis, Tennessee. Contact: Kelly M. Cole, RN, BSN, Tennessee Department of Health Health Promotion/ Disease Control Cardiovascular Health Program. (615) 253-2156;or e-mail kcole@mail.state.tn.us.

Sep 30–Oct 4: *Remembering the Past Building the Future*. The 2000 U.S. Conference on AIDS. Hyatt Regency Hotel, Atlanta, GA. Contact: Oscar Medrano, National Minority AIDS Council (NMAC) at (202) 483-6622 or visit http:// www.nmac.org

Oct 3–6: 5th International Conference on Diabetes and Indigenous Peoples, Christchurch Convention Center, Christchurch, NZ. Call: 64-371-3911; fax 64-371-3901; e-mail: info@diabetes2000.co.nz.

Oct 19-21: 'O ke Aloha Ka Mea I Ho'ola Ai Compassion is the Healer (Indigenous Healers Conference), Waimanalo, O'ahu, HI. Contact: (808) 259-7948.

Nov 12–16: *Eliminating Health Disparities*. American Public Health Association's (APHA) 128th Annual Meeting and Exposition. Boston, Massachusetts. Contact: APHA at (202) -777-APHA or visit http:// www.apha.org

Nov 29–Dec 1: 15th National Conference on Chronic Disease Prevention and Control. Washington, DC. Washington Hilton and Towers. Sponsored by the Centers for Disease Control. Contact: Dale Wilson at (770) 488-5885 or e-mail: dnw3@cdc.gov.