


HAU MEA

Transforming the Health of Native
Hawaiian Women and Empowering
Wāhine Well-Being



Haumea—Transforming the Health of Native Hawaiian Women and Empowering Wāhine Well-Being.

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Introduction

Within the Hawaiian worldview, feminine power is characterized as being both steadfast and progenerative in its energy.

Within the legendary lines of the Kumulipo, “the sacred Hawaiian hymn of creation” (Johnson, 1981), Haumea, Papa, and La’ila’i are powerful goddesses that represent the venerated female role of creation. “[T]heir prominence in the Kumulipo means that women are not effaced in the consciousness of the lāhui; both men and women take their parts in the creation and reproduction of life, and in the mo’olelo that follow” (Silva, 2004, p. 102).

Haumea, in particular, is a cherished ancestor to wāhine, as she is the matriarchal supreme being we know as the mother of Pele, Hi’iaka, and Kapo, and the grandmother of Hāloa, Wailoa, and Waia. Being the procreator of the Hawaiian universe, Haumea birthed the Hawaiian archipelago and everything within it, including the coral, marine resources, land creatures, and kānaka maoli (Native Hawaiians). Lilikalā Kame’eiehiwa (1999) notes that wāhine literally embody their ancestors through both their biological makeup and lasting ancestral memory. She describes these mechanisms which ultimately express kānaka ‘ōiwi (native bones) values through and across every generation. Wāhine are both the embodiment of their foremothers and of Haumea, with a wondrous body, an eightfold body, four hundred thousand bodies, four thousand bodies (Emerson, 1915) in all their physical and spiritual forms:

O kino ulu o pahu o lau ulu ia nei,
He lau kino o ia wahine o Haumea,
O Haumea nui aiwaiwa.
(Silva, 2004, p. 102)

*Breadfruit body, breadfruit trunk, breadfruit leaves,
One of the body forms of this woman Haumea,
Mysterious, great Haumea.*

The connections outlined in the Kumulipo between the Hawaiian people and nature reflect concepts of lineal descent that embody the same cultural elements that are evident in all Native Hawaiian relationships, values, rituals, and beliefs. Relationships to the living environment, ancestors, the ali’i (chiefs), and the akua (gods) are forged at birth and formed over the course of an individual’s corporeal and spiritual life.

Hawaiians believe they are descended directly from the mating of the earth mother, Papahānaumoku, with her brother Wākea, the sky father, from whom were born the islands of Hawai’i, the first taro plant, and Hāloa, the first divine Chief and first of the Ali’i Nui (gods that walked upon the earth). All Native Hawaiians descend from the Ali’i Nui, with commoners being the descendants of the junior lineages (Kame’eiehiwa, 1992 & 1999).

By merging the physical and metaphysical aspects of life, Native Hawaiians were able to conceptualize a foundation of reality that allowed the formation and maintenance of direct relationships between generations. The nature of these relationships was harmonious and dualistic, and even extended to Native Hawaiian understandings of male and female roles:

Man was the embodiment and instrument of the divine procreative mana that was always associated with nature superior; while woman, sprung from earth or sand, into which life was breathed or impregnated, forever belonged by reason of her origin and the dualism of nature, with the earth, or nature inferior. (Handy, 1927, p. 227)

Historical writings of ancient Hawai’i often omit or provide little detail about the role of women within the highly romanticized, male-dominated social structures. Yet, we know women were held in high regard in Hawaiian

society even though published and archived literature is found to be imbalanced in the author's voice, tone, and perspective. Besides making a myriad of social, economic, and political contributions, Native Hawaiian women were responsible for the perpetuation of mo'okū'auhau through procreation and birth—important manifestations of inherited mana that were transferred to future generations (Watkins-Victorino, Coleman, & Fox, 2014). Furthermore, Native Hawaiians believed that the mana associated with birth and creation enhanced the growth and prosperity of their society. According to anthropologist Bradd Shore (1989), “Perhaps most convincing in this vein are the complex associations throughout Polynesia between the containment of the reproductive powers of women and the capacity of chiefs to guarantee the natural fertility of the land and sea” (p. 163). Indeed, Native Hawaiian beliefs surrounding the vital role of women and procreation in ancient Hawaiian society emphasize the value in the power to ho'oulu a rising nation for future inheritance.

“Wā” can mean a period of time, an era, or to make a noise or to roar. “Hine” is the feminine essence. As an agency, the Office of Hawaiian Affairs (OHA) has the kuleana to ho'oulu lāhui aloha—to raise a beloved nation—and in order to do that, we must mālama our wāhine and care for the inequities faced by Native Hawaiian women in this contemporary period. Wāhine are literally the vessels that house the potential for our nation to perpetuate, to ho'omau. They are the first teachers of our children, kōko'olua to our kāne and fellow wāhine, the leaders of revolutions like the end of the 'aikapu and stewarding a return to our traditions in the 1970s. Our stories say that wāhine birthed our islands—the land base of our lāhui. Some say that if you want to heal a nation, you start by supporting its women.

About This Report

Haumea: Transforming the Health of Native Hawaiian Women and Empowering Wāhine Well-Being seeks to provide a wāhine perspective on the historic role of wāhine in ka wā mamua (the historical and traditional era) and of the well-being of wāhine today, o kēia au. In typical publications, this approach can be challenging due to the majority of 19th century Hawaiian scholars being of male gender and patrilineal perspectives. Conscientious effort has been made for the perspective of this report to

have its foundation based in Native Hawaiian female energy, by including as many wāhine voices and references as possible, coupled with a majority of its project team identifying as female. This report seeks to represent the same qualities consistent with the goddess Haumea in theory, approach, design and analyses for interpretation.

Major content has been organized into six chapters, each with a consistent framework that begins with an overview of the roles of wāhine in Hawaiian society and historical strengths that contributed to thriving communities. It is not an exhaustive historical analysis, and is intended to demonstrate cultural strengths that can help inform contemporary issues faced by wāhine today. Some of the nuances between maka'āinana (commoner) and ali'i (chiefly) customs are illustrated, as well as between the traditional hierarchical classes; however, customs were largely 'ohana-based (family-based) and unique to specific regions within the islands. Deeper analyses connect the spiritual essence of wāhine with the akua, 'aumākua, and kini akua (countless spirits and gods) who make up a beautiful tapestry of female leadership and authority. The chapters are organized by the following six areas:

1. Mental and Emotional Wellness
2. Physical Health
3. Motherhood
4. Partner Violence and Incarceration*
5. Economic Well-Being
6. Leadership and Civic Engagement

*Note: This section is available in the digital version of the report only.

The approach attempts to illustrate kānaka 'ōiwi theory via the framework of Kūkulu Hou (Crabbe & Fox, 2016; Crabbe et al., 2017), and how holding true to this history and beliefs revitalizes our cultural identity based within the worldview of our people and their emerging needs. The other focus is on practice and customs attributed to maoli strengths and excellence—to then bridge 'ike (knowing) with hana (doing).

Terminology

Included within this brief introduction is specific terminology (see Figure i.1) that we will reference when utilizing ʻōlelo Hawaiʻi toward females, girls, women. These hua ʻōlelo (terms) often refer to female qualities that are capture the Hawaiian thoughts of attribution like flowers, openings, and formations.

Figure i.1: ʻŌlelo Hawaiʻi (Hawaiian Language) Terms related to Wāhine

Term	Explanation
Wahine	Woman, lady, wife, sister-in-law, female cousin-in-law of a man; queen in a deck of cards; womanliness, female, femininity; feminine; in the context of this report “wahine” and “wāhine” also refer to Native Hawaiian females
Wāhine	Plural form of wahine
Kaikamahine	Girl
Kaikuahine	A sister of a brother
Kaikuaʻana	An elder sibling of the same sex, for example the elder sister of a woman
Kaikaina	A younger sibling of the same sex, for example the younger sister of a woman
Makuahine	Mother, aunt, a female cousin or relative of your parents’ generation
Kūpunawahine	Grandmother, grandaunt, female ancestor
Moʻopuna wahine	Granddaughter
Luahine, ʻelehine	Old woman, to be an old lady
Wahine hoʻowahine	A platonic wife, an old Hawaiian relationship
Wahine makua	An older woman, older sister in law or female cousin in law of a man
Wahine o ka pō	A female spirit lover, it was believed that a child born of such a mating might resemble an eel, lizard, shark, or bird, or might have supernatural powers; sometimes death or sickness followed nightly visits
Wai o ka wahine	Menstruation or other discharge
Haku wahine	Wife of a chief, lady, woman of high rank; female employer or supervisor
Aliʻi wahine	Chiefess
Hulilau	A large variety of gourd used for tapa or garments or food offerings. Figuratively refers to a woman, mother, or wife
Kaha pouli	A kapu on menstruating women, restricted them to the menstruating house
Kai wahine	A calm, gentle sea. Lit., feminine sea

Source: Pukui & Elbert, 1983

Methodology

This report makes significant usage of the Kūkulu Hou Methodology, which was developed by Dr. Kamanaʻopono Crabbe in 2009, and is rooted in the Native Hawaiian cultural practice of umu hau pōhaku (rock-wall masonry) (Crabbe & Fox, 2016). This practice was a fundamental aspect of constructing ancient temples, shrines, fishponds, houses, and other structures. Umu hau pōhaku required particular steps for gathering resources, site selection, construction planning, and skills training. The primary objectives of the Kūkulu Hou Methodology for research and reporting are fourfold:

- To articulate the historical-cultural context of resilient and positive cultural strengths of the Hawaiian heritage as a foundation of knowledge and practice;
- To highlight the contemporary disparities in the conditions of Native Hawaiians based on available data and research;
- To provide critical analyses of systemic barriers and/or challenges with parallel solutions; and
- To make recommendations to improve the conditions of Native Hawaiians, their families and communities, as well as the broader Native Hawaiian society or lāhui.

It should be noted that the sections of each chapter that discuss traditional practice are more narrative and historically based, as opposed to data-driven. Thus, the sources of information include traditional oral accounts that were preserved as moʻokūʻauhau (genealogies), moʻolelo (historical narratives), and mele (songs and chants). These primary sources record the long history of Native Hawaiians and were explored to affirm that Hawaiian society consisted of thriving lands, resources, and peoples. Finally, the work of contemporary scholars and academics were exhaustively researched and referenced where appropriate.

For the contemporary data sections, data from numerous sources were compiled to provide a context or

overview of how social, economic, and environmental factors impact Native Hawaiian women in Hawaiʻi. Major sources utilized include: the U.S. Census Bureau's American Community Survey, the *Native Hawaiian Data Book*, *The Disparate Treatment of Native Hawaiians in the Criminal Justice System*, the University of Hawaiʻi, the Behavioral Risk Factor Survey System and the Youth Risk Behavior Surveillance System. It also utilized data and factual information from recent publications which were published at the same time as this research was being conducted. Major sources of health status information include Hawaiʻi State Department of Health Hawaiʻi Health Data Warehouse datasets and research from the University of Hawaiʻi Cancer Research Center.

From all sources, the most recent data at the time of writing for Native Hawaiian women was extracted and analyzed. In most cases, this selection includes data from 2015 and 2016; except where sample sizes were smaller to disaggregate by both race/ethnicity and gender, five-year estimates were used. These estimates represent data that were collected over a five-year period, as opposed to a point-in-time count or a one-year data-collection period. Some of these estimates are from 2011. Data are also noted throughout the chapters where it may no longer be collected, therefore, no updated information is available but the topic was of importance to the project team and community interest. Other findings reference data for the Native Hawaiian population at large. Unfortunately, in some cases, data specific to wāhine were not collected or were unable to be annualized due to small sample sizes. In these instances, data for the larger Native Hawaiian population are referenced, along with data for the total State female population—the populations within which wāhine form a part.

Editorial note: Proper Hawaiian names of people, places, and nouns are spelled according to the source text within the reference, except where the name is used by the author in narrative or in references to well known names. Those spellings and diacritical markings are utilized in Pukui & Elbert, 1986.

Current Demographic Information

U.S. TOTAL

- There were 265,170 Native Hawaiians females in 2010. The median age of wāhine is 27.1 years

HAWAI'I

- Of the 144,121 Native Hawaiian females in Hawai'i in 2010—66,019 or 46% were 24 years old and younger.
- The median age for the 679,058 State females was 39.9 years.
- The median age for wāhine in Hawai'i is 27.8 years.
- The median age of Native Hawaiian females is slightly above Native Hawaiian males of 26.3 years.

Source: United States. Bureau of the Census. Census 2010 Summary File 2 (SF 2) (February 23, 2012).

Figure i.2: Native Hawaiian Population Totals

	US Native Hawaiian			State of Hawai'i			Native Hawaiian		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
All ages	261,907	265,170	527,077	681,243	679,058	1,360,301	145,849	144,121	289,970
Median age	25.8	27.1	26.5	37.2	39.9	38.6	26.3	27.8	27.1

Source: OHA , 2017; US Bureau of the Census, US Census 2000, 2010)

Life Expectancy

In 2010, life expectancy for Native Hawaiians at birth was 76.6 years: wāhine, 79.4 years; and kāne, 73.9 years, a 5.5 year difference. The life expectancy for women in Hawai'i was the lowest among Chinese (90.0), Filipino (88.1), Japanese (88.0), and Caucasian (83.4) (DEBEDT, 2017, p. 123).

Dr. Jamie Kamaileani A. Boyd: A Kānaka Makua Genealogy

Dr. Jamie Kamaileani A. Boyd knows firsthand the power of ancestral intelligence and ‘ohana in overcoming tremendous challenges, and looks specifically to the women who raised and nurtured her.

The first Native Hawaiian woman to earn a Ph.D. in nursing from the University of Hawai‘i, Boyd was raised in the traditional Hawaiian hānai system. With a mother largely out of the picture, she and her siblings were hānai to their paternal grandparents, who imparted lessons and values Boyd continues live by.

Boyd’s grandmother, a traditionally trained nurse who took patients into her home for long periods of time, taught Boyd how to give without expectation of return and to always show consideration, using gentle discipline to shape her grandchildren’s behavior. “My grandmother had tight wings over us. Those lessons are a little harder to impart now,” says Boyd. Parents today raise their children to be assertive and independent, but Boyd was raised to become kānaka makua, “that idea you grow up to be a responsible, reasonable adult with those sets of skills.”

However, her grandmother passed when she was nine. “What I wouldn’t give to hear her one more time,” she says wistfully. She then became a ward of the Queen Lili‘uokalani Children’s Center where she met other kānaka makua through hānai and foster ‘ohana, and other wāhine who offered different life lessons along the way. She and two siblings moved in with an ‘ohana

that already had 14 children. It was a hard year, but she learned a lesson about compassion: “Even though you have 14, you don’t say no—you stretch it more than you have.”

Having nothing herself, Boyd fondly recalls a woman who gave her and her sister little gifts as they passed her home on their way home from school—an apple or an orange, and once a small, inexpensive nail care kit the girls thought was “the Hollywood of presents.” From this kānaka makua, she learned, “You have to keep the porch light on and the door open,” she says. For kids growing up in chaotic environments, a little break in the day and something kind means a great deal. “Adults have to build a reputation that you’re safe here.”

Boyd draws on skills learned from other kānaka makua: her ‘anakē and a hānai mother who was a police dispatcher taught her to stand up for herself and not let anyone make her a victim—to kick

and scream if she had to; another told her to always forgive and to always bless; and yet another hānai mother demonstrated aloha as she sat in the back of a station wagon stringing lei to sell at the airport.

When Boyd became pregnant while in foster care, everyone assumed she would give up the child, as did Boyd until a social worker at the Queen Lili‘uokalani Children’s Center asked her what she wanted. “I told her I would like to have a nice house, with a handsome husband and a nice car, and we go on vacation together. The social



worker said, ‘Well, go do that,’” remembers Boyd, who has manifested it all as mother of three adult children and one stepson from her husband of 30 years. “I’m Dr. Boyd now, which no one ever told me was a possibility.”

Boyd draws on skills learned from other kānaka mākuā: her ‘anakē and a hānai mother

A social services worker at the State hospital taught Boyd to know available resources—something that Boyd remains passionate about as she works with young women in the Windward Community College’s Pathway Out of Poverty program, exploring ways to make education affordable and accessible for her students. From the social worker, Boyd learned to take the only resources she needed with the intention of leaving the rest for others. “What she imparted was I don’t need public resources at all. I can work and I can rake my neighbors’ leaves, iron my neighbors’ clothes or do what I need to do instead of applying for those resources,” Boyd notes. By 15, she was working and saved enough to move into her own apartment on Mother’s Day that year.

In her current roles as a nurse practitioner, professor and director of the Pathway Out of Poverty program, Boyd comes into contact with a lot of young Hawaiian mothers. Today’s young wāhine and mothers shoulder tremendous burdens as they balance work, housekeeping, and childcare, often in relative isolation, Boyd notes. When she asks who they can turn to for support, “They say, ‘my sister, but she’s busy. My mom, but she works.’ They don’t automatically say, ‘I go back to the kuleana. I go back to the homestead,’” Boyd observes. “Even when there is a homestead, Hawaiian Home Lands or something, I still see families coming from there that don’t talk

about managing the pilikia from the homestead perspective. Everyone is just trying to pay their own mortgage and their own car payment.”

Boyd suggests, “We need to go to the pu’uhonua,” to give women community, a metaphorical “place of refuge” where the wāhine can identify who they are and what they need in order to be everything they can be.

When she was young, “We wouldn’t differentiate because all the mothers would be helping you. And the mothers that didn’t actually hānau would still be mothers. It’s a very different thing now, that a mother is she who has hānau ‘ia ke keiki as opposed to she who didn’t,” Boyd explains. As a result, she dismisses as a modern concept the idea of a singular relationship between parent and child, saying instead that there is a whole village of women and mothers. “The makua are all the people in our age group, period. And we all have a responsibility to mālama, to hanai the young.”

Today, Boyd works with other young people—many of them single mothers—to help them advance their careers from nurse’s aide to registered nurse. She recognizes students are pushed toward science, technology, engineering and mathematics (STEM), even if their aptitude is better suited to traditional callings. “Go send them with the mahi ‘ai, with the lawai’a, send them with the carvers, wherever, and give them a trade and tell them how fabulous they are as tradesmen,” she says. “But then society says, ‘Oh, your kid is only a carver?’” Her curriculum looks at healing practices from two perspectives—students learn how to recognize certain conditions and the western ways of treating them, but Boyd also takes students to a medicinal garden on campus so they can also learn how use lā’au lapa’au, pule, and lomilomi to treat the same ailments.

Now that her children have started their own families, Boyd shares Hawaiian traditions and values with her 10 grandchildren, much in the way her grandmother did with her. “I think for all of us mothers, what’s actually happening is that we’re in training to be the kūpu-na. I don’t know that any of us can speak to how we’ve mastered mothering. I’m definitely 99 percent better at mothering, grandmothering, with so many lessons learned from the many kānaka makua. The rulemaking and heavy-handedness that I was taught was mothering in some foster care environments, I eventually learned was not necessary.”

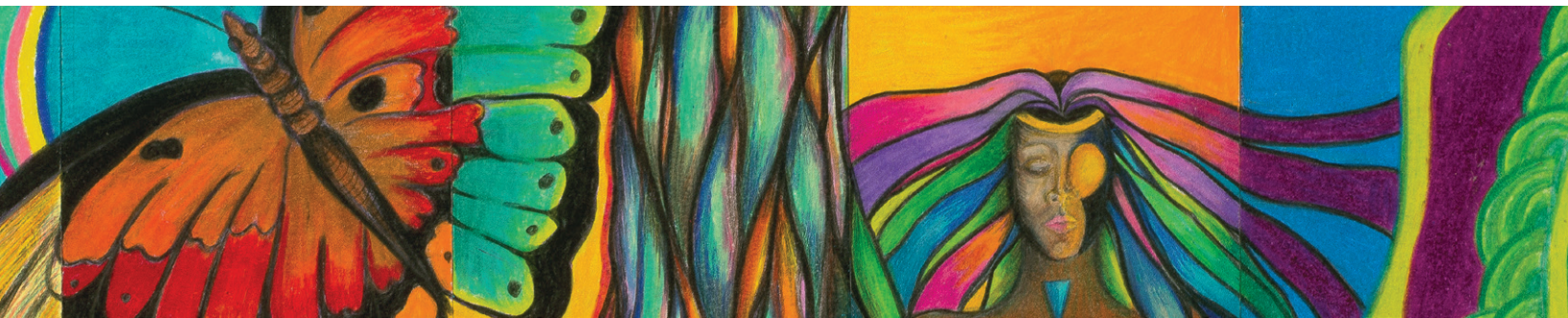
Mental and Emotional Wellness

CHAPTER 1

E hānai ‘awa a ikaika ka makani.

Feed with kava so that the spirit may gain strength.

(‘Ōlelo No‘eau, #275)



Issue Data for Intervention: Mental and Emotional Wellness

- » More Native Hawaiian females in public high schools (24.1%) seriously considered attempting suicide, compared to non-Hawaiian females (18.7%) and females statewide (20.1%).
- » Female ‘ōpio in 9th grade report the highest rates of self-harm in the State (42.2%). This is more than three times higher than the state rate for non-Hawaiian male youth in the same grade (13.7%).
- » During 2012 to 2016, nearly one in five wāhine considered their mental health “not good” for 1 to 6 days of the month (19.3%).
- » Among Native Hawaiian adults from 2012 to 2016, wāhine had the highest rates in the state while considering their combined physical and mental health were “not good” for 7 to 13 days of the month (11.2%).
- » Nearly 1 in 10 Native Hawaiian kūpuna have depressive disorder.

Throughout this report, physical health and emotional wellness are integrated concepts to maoli models of balance; which if left unaddressed, leads to further distress and a sense of being emotionally burdened. An important cornerstone in the social well-being of Hawaiian society is pilina (associations, relationships, connections). Tending to those pilina was the foundation for prosperity in ka wā mamua. In traditional communities, family members relied on each other for survival and, through cultivating, sharing, and caring of natural resources, strengthened family and community relationships. These relationships are noted for practices of aku and mai, in reciprocity that was interrelated, holistic, and never one-sided. Within those pilina were spiritual connections to akua and familial ‘aumākua (ancestral gods) who ensured that daily life was carried out with efforts to balance the physical, spiritual, mental and emotional aspects of healthy living. We carry these same bonds with us in kēia au (present time); binds that remain unbroken from generation-to-generation or community-to-community. The emotional essence of how we connect to one another forms a core foundation

to understanding Hawaiian perceptions of mental and emotional wellness today. This chapter will integrate the Hawaiian approach to balance while introducing significant issue data that need intervention for Native Hawaiians today, though should be thought to encompass the other chapters for a more complete outline of how to protect and heal our na'au (seat of emotions).

Pilina 'Ohana

Families who lived mauka (toward the mountains) shared their kalo (taro) or 'uala (sweet potato) crops with other 'ohana who lived makai (toward the ocean), and those families shared the bounty of the ocean with those up mauka. The 'ohana included a multi-generational household where kūpuna, kāne, wāhine, keiki, and hānai (adopted children) all lived together. Children were often raised by kūpuna (grandparents) within their 'ohana while heavy work was carried out by the stronger mākuā (parents).

One's place in genealogical sequence was more important in Hawaiian upbringing than age or gender (Handy & Pukui, 1972). For example, a younger female cousin would be the kaikua'ana (elder sibling) of an older male cousin, the kaikaina (younger sibling), if her father was born before the male cousin's mother, who are siblings. The kaikua'ana had a responsibility to care for the kaikaina, and the kaikaina had a duty to support their kaikua'ana. Thus, kuleana was shared between and within generations and lōkahi experienced in 'ohana.

The 'ohana primarily dwelled in kauhale (housing complex). There was a hale mua for the men, where they prayed to their akua and ate; a hale noa that was open to everyone, where the family slept; and a hale 'aina where the women and children ate. Keiki kāne (boys) ate in the hale 'aina with the women until they were kā i mua, or "thrust into the mua house" with males (Handy & Pukui, 1972). It was at this time that they began to observe the 'ai kapu with the men in the hale mua and wear a malo (Malo, 1903; Pukui & Elbert, 1972). Another separate house, the hale pe'a, was reserved for the females when

they were haumia, or menstruating. Other hale were dedicated for specific functions where those in the kauhale had roles to oversee and upkeep for communal harmony. Accordingly, there was dedicated time, places, and role for wāhine in the kauhale but also for kāne.

Pilina were not simply transactional, but were shown in the deep love and admiration created through romantic relationships of kānaka couples, and expressed extensively in pule, mele, ka'ao, mo'olelo, oli and hula. Fondness, esteem, and passion was a part of daily life and chronicled for us today (Beckwith, 1970; Kanahele, 1986; Kepelino, 2007). Other pilina such as aikāne, or same-sex relationships, existed among both kāne and wāhine. An aikāne was often a beloved and dear friend or companion; some scholars believe this to include sexual relations (Kame'eleihiwa, 1992) and others consider it strictly platonic (Handy & Pukui, 1972). Kamehameha III's aikāne, Kaomi, was half Tahitian and half Hawaiian (Kamakau, 1996) and was said to be a skilled healer (Kamakau, 2001). Ka'ahumanu was also known for frequently taking women as her aikāne (Kamakau, 2001). Subsequent research will focus on 'aikāne and kōko'olua (partners), as well as mähū and ho'okāmaka (same-gender sexual practice) within 'ohana and pilina with respect to non-binary genders and sexual identity.

To balance these pilina and address mental or emotional strife, those in the kauhale practiced ho'oponopono, which targeted the root of the disturbance within the individual or family. This required group participation through behavioral and emotional acknowledgment of the individual and environment. Creating healthy individuals and families was achieved by engaging the metaphysical power of healing through the restorative process of forgiveness. Luomala (1989) described ho'oponopono as "mental cleansing" (p. 290) and integral to the cooperative approaches for healing to restore well-being for the collective. *Nānā I Ke Kumu* explains this emotional healing which "ensured harmonious interdependence within the 'ohana through regular family therapy (ho'oponopono); dealing with each successive layer of trouble (mahiki); forgiving fully and completely (mihi); and freeing each other completely (kala). It is this knowledge that the Hawaiian needs to recapture" (Pukui, Haertig & Lee, 1972, p. vii).

AKUA, 'AUMĀKUA, AND PULE

In ka wā kahiko, a fundamental part of everyday life was pule and “for the Hawaiian of the past, all times and every time were indeed occasions for prayer” (Pukui, Haertig & Lee, 1979, p. 121). Pule enabled people to communicate with akua and ‘aumākua, when asking for permission, assistance, or forgiveness. ‘Ōiwi also believed that there was life in words and that words “took on existence and function as soon as they were spoken” (Pukui, Haertig, & Lee, 1972 p. 175); therefore the kaona and multiple meanings of words were carefully considered when composing pule or reciting them (Pukui, Haertig & Lee, 1979). The Hale o Papa, located outside the walls of a heiau where kāne conducted ceremony, was where “religious services were held for women” (Pukui, 1986, p. 53). Issues such as famine, infertility, illness, and death were addressed at the Hale o Papa (Kamakau, 1996). Some sources state that it was in fact kāne that oversaw ceremony at Hale o Papa (Jensen & Jensen, 2005), and the literature is not clear if wāhine themselves actually conducted ceremony there or attended and had specific functions. Research from Masse (1991) describe the Hale o Papa quite specifically in relation to heiau (high place of worship) on Hawai‘i Island: “A hale o Papa is the temple structure where female deities are housed and where women of chiefly rank commingle with men at the end of one or more of the luakini rites, thus breaking the kapu imposed during the luakini ritual itself” (p. 38). Additional research to better understand the Hale o Papa is needed to provide clarity to kulana in this place compared to the other hale structures in the community. (For an example of Hale o Papa see, Chapter 4: Incarceration and intimate Partner Violence)

Generally, wāhine traditionally engaged with the akua that pertained to the particular practices they were involved in, such as Maikohā, an akua associated with kapa making (Pukui & Elbert, 1971). From the building of a hale (house) to the building of a heiau, there was an associated akua and pule. An akua wahine named Laea was prayed to by women and canoe-builders (Malo, 1903), as was the elepaio (flycatcher) bird (Beckwith, 1970). Akua wāhine were also called upon by kāne to impart political power to their rule, such as Kahekili and Kamehameha who called upon the akua wahine Kameha‘ikana and Kūho‘ohē‘enu‘u (Kamakau, 1996).

Pule enabled people to communicate with akua and ‘aumākua, when asking for permission, assistance, or forgiveness.

Mo‘o were guardians of fresh water and often lived in or near freshwater sources such as streams, springs, or fishponds and were predominantly wāhine. The supreme mo‘o was Mo‘o‘īnanea who came from Nu‘umealani to Waialua, O‘ahu and brought with her all the mo‘o of O‘ahu. One of them was Laniwahine, the mo‘o who guards the fishpond of Uko‘a in Waialua, O‘ahu (Manu & Pukui, 2002).

‘Aumakua were also prayed to by entire families and their descendents (Pukui, Haertig & Lee, 1979). Families only prayed to their ‘aumākua and never to those of another family. ‘Aumākua, like akua had many forms, could take the form of a manō (shark), honu (turtle), puhi (eel), or even a ‘iole (mouse). ‘Aumākua could punish their descendants for wrongdoing or help them in times of need. Akua, ‘aumākua, and pule are significant areas for exploring the interconnected spirit to maoli traditions, past and present, because they represent the interconnected ideals of kānaka mindset. Where balance for wellness is vertical, horizontal, and all encompassing.

‘AWA

The importance of medicinal plants to Hawaiian well-being can be explored through the use of ‘awa (kava, Piper methysticum) and its connection to the akua, ‘aumākua, pule and ceremonies of ho‘omana (to generate mana). The association of ‘awa with the primary Hawaiian gods reflects the sacred nature of its consumption and offering, particularly its mixture with wai (water) being understood as a life giving concentrate.

Only the most common variety of ‘awa could be used by the commoner; the rarer kinds were reserved for the chiefs. “The drinking of kava is thus a communion... The story of the kava includes the bad and the good, the

bitter with the sweet” (Chun, 1986, p. 36). There were significant differences in ‘awa consumption between and among ali’i and commoners related to the additional protocols and regulations set for its use throughout the realm (Chai, 2005; Winter, 2004). The methods of assembly are prescribed by the gender and class roles among the ancient society. According to Luomala (1989), chiefs and commoners drank it before meals and at night to ease muscular fatigue and soreness, and to

Feed with kava so
that the spirit may gain
strength. (Pukui, 1983, #275)

induce sleep (p. 300). Restoring health through sleep is a long known treatment aspect by Hawaiian lapa‘au and lomilomi practitioners. The hierarchy associated with ‘awa consumption was directly related to “the manner of its use indicat[ing] rank” (Titcomb, 1948). Regulations of use and consumption were the result in part of the availability of the plant. The sociopolitics associated with land governance by the ali’i also limited maka‘āinana consumption (Chai, 2005).

Kāwika Winter’s (2004) ethnobotany research analyzes female consumption of ‘awa among akua, ali’i, and maka‘āinana for ceremonial, medicinal, relaxation, and general enjoyment. Among the female akua, Papa, Pele, Hi‘iaka, Laka, Malei are described in various ‘oli for the use of hiwa (black), mō‘ī (royal), papa (recumbent) varieties of ‘awa (Winter, 2004). Pule for wāhine from wāhine are described in positive ways in which females partook in the spiritual and physical uplifting that ‘awa consumption brought to their mental and emotional balance. Thus the ‘ōlelo no‘eau which opens this chapter: “E hānai ‘awa a ikaika ka makani.” *Feed with kava so that the spirit may gain strength* (Pukui, 1983, #275).

DEATH AND MOURNING PRACTICES

When someone passed away it was believed that their ‘uhane, the spirit that continues after the body dies, traveled to a leina or leaping point where it was led into the ao ‘aumakua (Kamakau, 1991a). One such place was at Leilono at Moanalua, O‘ahu. If their ‘aumakua was there to greet them, they would go to the ao ‘aumakua, but if there was no ‘aumakua, they would wander to the ao kuewa (realm of homeless spirits) (Pukui & Elbert, 1983). Ali’i wāhine were included in this practice to elevate the dead to the rank of goddess so that they could be idolized for eternity on earth, the ao kanaka. Kihawahine, a chiefess from the island of Maui, became a mo‘o goddess associated with the color yellow. She was worshipped on Maui and Hawai‘i Islands at heiau, including those established by Kamehameha I; moreover, he initiated her ki‘i with a prostrating kapu as a sign of deference. Her home is thought to be at the Haneo‘o loko i‘a where she dwells as a guardian goddess in Hāna, Maui (Beckwith, 1970; Pukui, Elbert & Mo‘okini, 1974).

After death, mana still resided in one’s iwi (bones); thus, the iwi of the ali’i were carefully hidden. The iwi were often dedicated to powerful akua to be worshipped by the family in order to maintain their emotional connections. One such goddess was Kalamainu‘u who ruled the mo‘o. Upon spiritual dedication, the body of the dead was said to be changed into that of the mo‘o, who thereafter became their familial protector as ‘aumakua (Beckwith, 1970). Using her other names as Kalanimainu‘u and Kalanimaimu, “houses called puaniu were erected to her for deifying the dead” (Beckwith, 1970, p. 125) where these ceremonies would take place within the kauhale.

Ka po‘e kahiko had different mourning practices to cope with grief. Grief and loss being a significant concept in Hawaiian mental and emotional entanglement connected to perceptions of sadness and depression. During the funeral processions of the ali’i, mourners pulled out their hair, knocked out their teeth, and hit their chest (Kamakau, 1996). At the death of Keōpūolani, Kamāmalu tattooed her tongue over the grief of her husband’s mother’s death (Buck, 1957). These practices were thought to restore emotional health through this “brief extravagant conduct” (Jensen & Jensen, 2005).

Grief over an ali'i's death was also shown through the practice of moepu'u, voluntary death companions of the ali'i. It is said that a greatly loved chief had many moepu'u (Kamakau, 1996). Various people accompanied Kamehameha at the end of his life in case he passed away, so that they could be his moepu'u (Kamakau, 1996). Upon the death of Keōpūolani, many people had pleaded to be moepu'u, but due to her having converted to Christianity, she requested that there be no moepu'u or ka'akūmakena (lamenting) (Kamakau, 1996). Moepu'u were also people who were killed during the burial of an ali'i to minimize who knew the placement of the ali'i's bones (Pukui, 1986). In some instances, if a child died, their pet dog might be killed and buried as a death companion (Titcomb, 1969).

Rarely, ka po'e kahiko committed suicide, or attempted it. Ka'ahumanu was known for attempting to commit suicide by drowning herself, until a boy tried to save her, at which time she came back to shore for fear of the child drowning (Pukui and Elbert, 1972). Pukui cites that she was jealous of Kamehameha taking her sister, Kaheiheimalie, as wife (1983). Written accounts of suicide among kōnaka have mostly been noted due to a tragic event or the emotion of jealousy. Shame was another reason people committed suicide (Pukui, 1983), such as with Kalaniakua, an ali'i who committed suicide by drinking poison because of the shame placed upon her by other chiefs that she was a "homeless chief" who relied on the protection of others (Li, 1963). Otherwise, this reporting analyses did not reveal open practices of suicide as regular use among maka'āinana.

Mental and Emotional Health: Youth and 'Ōpio

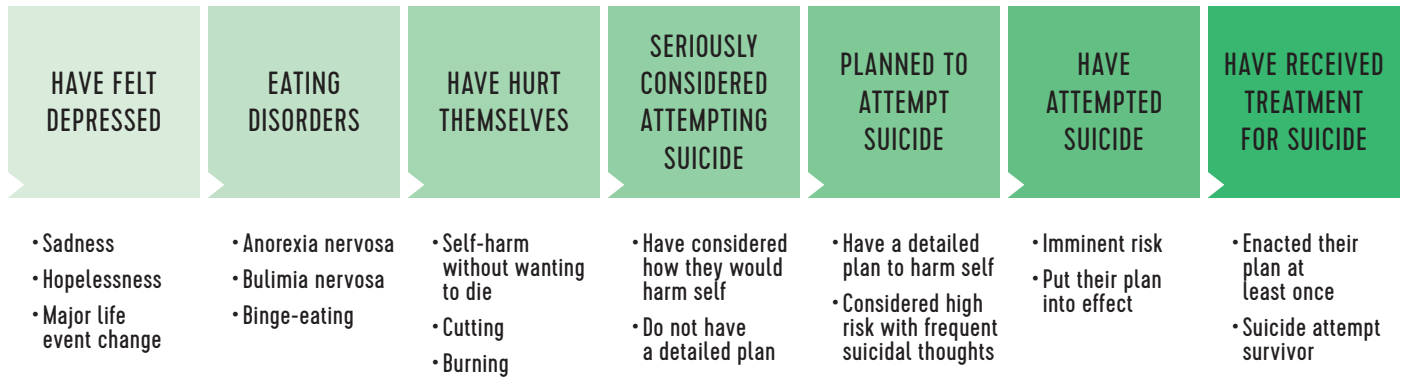
Globally, there are 1.2 billion adolescents between ten and eighteen years of age ('ōpio), of which 600 million are adolescent girls. Adolescence is a time of great change—physically, socially, and emotionally. This is a time when young girls are transitioning into their reproductive years and maturing into young adults. During adolescence, it is essential that girls are provided the necessary supports to foster healthy development. These supports can come in several forms: access to quality education, access to reproductive health care, healthy lifestyle promotion, support from family and trusted adults, and improved social environments.

Young adults aged 19–25 are often grouped with adolescents in conventional research, despite the different contextual experiences and encounters that influence their health behaviors. This period is often associated or described as a two-fold transitional time, where young adults have less access to social safety nets they received as children or adolescents and are taking on more responsibilities as adults (Park, 2006). Young adults have reached the time in their lives where they are completing their education, entering the workforce full time, developing long term relationships, and starting families (Bonnie et. al, 2015). There are increased opportunities to engage in risky behaviors as young

O Pele la ko'u akua
Mihi ka lani, mihi ka honua.
'Awa iku, 'awa i lani,
Kai 'awa'awa, ka 'awa nui a Hi'iaka,
I kua i Maui-ola,
He 'awa kapu no na wahine,
E kapu!
Kai kapu ko'u 'awa, e Pele-a-honua-mea,
E kala, e Haumea wahine,
O ka wahine i Kilauea,
Nana i eli a hohonu ka lua.
O Mau-wahine, o Kuku'ena [Kuku'ena]
O na wahine i ka inu-hana-'awa,
E ola na akua malihini!

*Pele is my goddess,
Let there be silence in the heavens, silence on the earth.
For the straight-growing 'Awa, the heavenly 'Awa,
The bitter juice, the great 'Awa of Hi'iaka,
That was cut down at Maui-ola,
It is 'Awa dedicated to the women,
It is sacred!
Let your 'Awa be sacred indeed,
O Pele-honua-mea. Proclaim the kapu, O Haumea-the-woman,
The woman at Kilauea.
It was she who dug the pit until it was deep.
Mau-wahine and Kuku'ena
Were they who prepared the drinking 'Awa,
Long live the gods from foreign lands!*

Figure 1.1: Phases and Risk Behaviors in 'Ōpio



adults are becoming more independent and experience less constraints. This results in a peak in substance use, alcohol use, and exposure to other factors that have adverse impacts on one's health. The role of women and the longevity of their health status can be easily defined at this stage of their life.

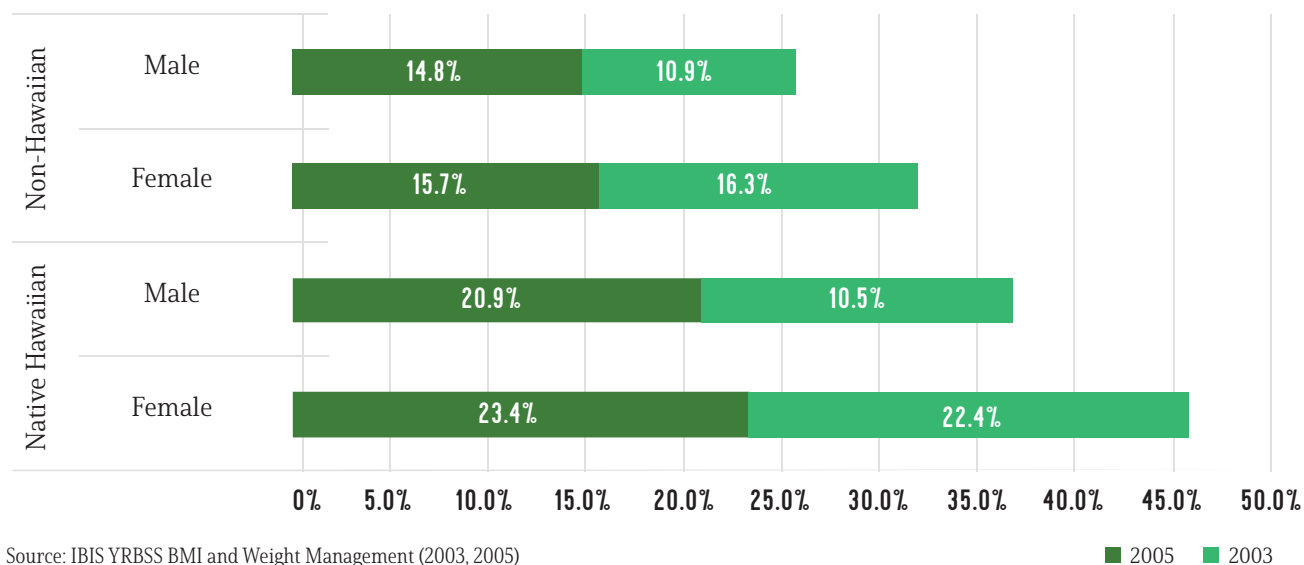
'ŌPIO RISKS

The Youth Risk Behavior Surveillance System (YRBSS) monitors types of health-risk behaviors that contribute to the leading causes of death and disability among youth (CDC, 2017). Questions in the YRBSS measure sadness, eating disorders suicide ideation, attempted suicide, and the seriousness of those attempts. These are interconnected indicators to help measure, track, and help 'ōpio through their adolescence. "Sexual and dating violence victimization are associated with a range of negative consequences, including suicide ideation and attempts, major depressive episodes, increased alcohol and tobacco use, eating disorders, and risky sexual behavior" (CDC, 2017, p. 9). The graphic above presents a spectrum for understanding phases and risk behaviors among the 'ōpio data presented.

DISORDERED EATING

"There is a commonly held view that eating disorders are a lifestyle choice. Eating disorders are actually serious and often fatal illnesses that cause severe disturbances to a person's eating behaviors. Obsessions with food, body weight, and shape may also signal an eating disorder. Common eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder" (National Institute of Mental Health, 2013). These three eating disorders are usually found comorbid with other anxiety disorders.

Among middle school students in Hawai'i, both Native Hawaiian and non-Hawaiian female eating disorder behaviors increased from 2011 to 2013. With nearly an 8% and 5% increase in one survey cycle, respectively, the link between adolescent female mental health and their eating behaviors should be a topic for further discussion and analyses. For 1/3 of Native Hawaiian females and 1/4 of non-Hawaiian females to indicate anxiety signaled by their eating patterns demonstrates a disturbance among young girls in Hawai'i beginning early in their identity development and self-care behaviors (IBIS YRBSS BMI and Weight Management, 2009–2013). Looking back further, in 2003 and 2005 middle school students in Hawai'i were surveyed. This includes students who fasted, vomited, or took laxatives, diet pills, powders, or liquids without a doctor's advice, to lose weight or to keep from gaining weight. Important to note is the rate at

Figure 1.2: Middle School Eating Disorder Behavior (30 days) by Gender (2003, 2005)

which Native Hawaiian males reported eating disorder behaviors compared to non-Hawaiian females during the same time period. In this table you see that kāne ōpio (20.9%) reported 5.2 percentage points higher than non-Hawaiian females (15.7%) in 2005.

Among high school, prevalence is higher for female students than for male students. The prevalence for Native Hawaiian students is higher than for non-Hawaiian students, when comparing both binary genders. In the most recent year of available data, 2013 prevalence indicated that Native Hawaiian females were 7.5 percentage points higher than non-Hawaiian females. This same year, Native Hawaiian male students were 3.1 percentage points higher than non-Hawaiian males. Topics assessed among youth included: trying to lose weight, weight control by eating less, weight control by exercise, any disordered eating behavior, weight control by fasting, weight control by prescribed drug use, weight control by vomiting or laxatives. Comparing these trends and indicators over time and in line with the national YRBSS continues to be a need, and would afford more useful information to monitor the increasing trends, as demonstrated in the following graph, especially among non-Hawaiian males and females. Further, it would allow

researchers, behavioral specialists and mental health professionals to examine the 6.1 percentage point increase of Native Hawaiian high school females between 2011 and 2013.

It would be helpful to continue to include these questions within the YRBSS for both middle and high school students. Adolescent and school health programs can help detect anxiety disorders, to include eating disorder behaviors, to help students treat their mental and emotional health.

DEPRESSION

The most symptoms of depression felt by Hawai'i adolescents are among Native Hawaiian females (37.7%). Among those, 9th grade wāhine experience feelings of sadness or hopelessness at the highest rates (47.7%) in the State; significantly greater than non-Hawaiian females (35.4%) and 10.0 percentage points higher than the State (37.7%). This is more than double the rate of young kāne in the same grade (20.1%). Non-Hawaiian female students experience these same feelings at the highest rates during 10th grade (44.9%).

Figure 1.3: High School Eating Disorder Behavior (30 days) by Gender (2009–2013)

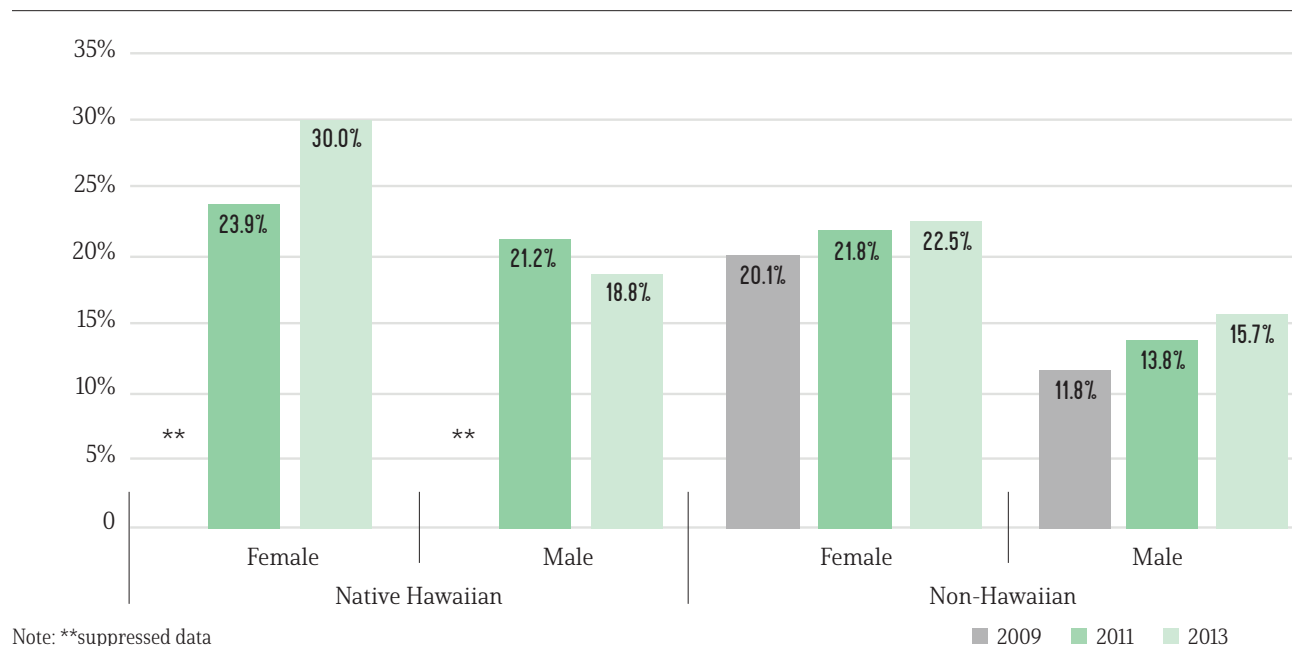


Figure 1.4: Percent of High School Students Who Have Felt Depression by Gender and Grade (2015)

Ethnicity	Gender	Grade				All High School	Overall
		9th	10th	11th	12th		
Native Hawaiian	Female	47.7	37.8	29.5	34.0	37.7%	31.2%
	Male	20.1	24.8	29.7	26.3	25.1%	
Non-Hawaiian	Female	35.4	44.9	30.8	31.7	36.1%	29.2%
	Male	20.8	19.0	26.8	21.8	21.9%	
State	Female	37.7	42.9	30.6	32.3	36.2%	29.5%
	Male	20.7	20.4	27.3	22.3	22.4%	

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Youth Risk Behavior Survey (YRBS)

SELF-HARM

Moving from feeling symptoms of depression along the spectrum toward data indicating high school ‘ōpio harming themselves, such as cutting or burning themselves, we note similar trends. Native Hawaiian ‘ōpio—both wāhine and kāne—experience the highest rates of hurting themselves compared to non-Hawaiians and the State rates, as shown in the tables below.

In 2015, 33.7% of Native Hawaiian females reported that they did something to purposely hurt themselves without wanting to die, such as cutting or burning themselves. This is 8.0 percentage points higher than non-Hawaiian females (25.7%) and 6.2 percentage points higher than females statewide. Female ‘ōpio in 9th grade report the highest rates of harming themselves in the State (42.2%). This is more than three times higher than the State rate for non-Hawaiian male youth in the the same grade (13.7%). In 11th grade, youth kāne (27.3%) exceed harmful behaviors toward themselves more than Hawaiian females by 4.5%.

IDEATION OR THOUGHTS

While analyzing the data on high school students who seriously considered attempting suicide by gender and grade, there is a trend in the vulnerability of young Hawaiian females. Among public high school students, suicidal ideation is most prevalent among 12th grade Hawaiian females at 28.5%. This is more than double the considerations of suicide attempt by State males, non-Hawaiian males, and Hawaiian males in 12th grade. Further, the next highest rates show 10th grade as the time when more ‘ōpio (male and female combined) are seriously considering suicidal attempt (47.4%).

In 2015, 24.1% Native Hawaiian females seriously considered attempting suicide compared to 18.7% non-Hawaiian females and 20.1% of females statewide. In 2015, 24.1% Native Hawaiian females seriously considered attempting suicide, this is 8.6 percentage points higher than Native Hawaiian males (15.5%).

Figure 1.5: Percent of High School Students Who Have Hurt Themselves by Gender and Grade (2015)

Ethnicity	Gender	Grade				All High School	Overall
		9th	10th	11th	12th		
Native Hawaiian	Female	42.2	37.3	22.8	31.4	33.7%	27.7%
	Male	19.1	23.2	27.3	15.9	22.2%	
Non-Hawaiian	Female	33.4	25.1	23.5	19.4	25.7%	21.1%
	Male	13.7	14.4	16.9	19.6	16.1%	
State	Female	35.8	28.4	23.3	21.7	27.5%	22.6%
	Male	14.9	17.2	19.5	19.5	17.6%	

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Youth Risk Behavior Survey (YRBS).

Figure 1.6: Percent of High School Students Who Seriously Considered Attempting Suicide by Gender and Grade (2015)

Ethnicity	Gender	Grade				All High School	Overall
		9th	10th	11th	12th		
Native Hawaiian	Female	26.1	27.7	15.1	28.5	24.1%	19.6%
	Male	11.9	19.7	15.5	13.1	15.5%	
Non-Hawaiian	Female	21.9	22.3	14.4	15.6	18.7%	14.8%
	Male	9.2	10.5	11.2	12.0	10.6%	
State	Female	23.3	23.1	15.2	18.1	20.1%	16.0%
	Male	9.9	12.8	12.4	11.8	11.7%	

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Youth Risk Behavior Survey (YRBS)

PLAN

In 2015, one in five Native Hawaiian females of all grades in high school made a plan about how they would commit suicide, slightly higher than non-Hawaiian females (18.2%) and of females statewide (18.8%). Almost one in four (23.3%) Native Hawaiian females planned a suicide attempt in the 10th grade, compared to one in five (20.0%) non-Hawaiian females of that grade level. Regarding Hawaiian males, they too were most likely to plan suicide in 10th grade (16.5%), making them 5% more likely than their non-Hawaiian peers (11.3%) in the 10th grade. Among Native Hawaiian peers, the greatest difference in planning was in 9th grade, where there is a 9.5% difference in wāhine as opposed to 'ōpio kāne. Ninth grade is also the greatest gap in planning rates among non-Hawaiian peers, at 12% for girls versus boys. Statewide, for Hawaiian or non, the data indicates a need to address the mental and emotional health of girls by 9th grade in order to reduce suicide planning rates into 10th grade.

ATTEMPT

Tenth grade Native Hawaiian females (19.4%) attempted suicide almost four times more often than non-Hawaiian males (5.2%). The amount of Native Hawaiian males in the 10th grade who made attempted suicide more than double their non-Hawaiian peers (11.0% vs. 5.2%). In fact, 'ōpio kāne attempt suicide at rates higher than the the State and their non-Hawaiian peers in every high school grade. None is more disparate that in 11th grade where 'ōpio kāne are 66% more likely to attempt suicide than non-Hawaiians in the same grade. Among 'ōpio wāhine, there is a similar pattern: the amount of Native Hawaiian females in the 10th grade who made attempted suicide more than double their non-Hawaiian peers (19.4% vs. 8.2%).

It should be noted that among 9th and 10th graders, Native Hawaiian females attempt suicide at higher rates than kāne. However, at 11th and 12th grades, Native Hawaiian males (16.1% and 11.6%) attempt suicide at higher rates than wāhine (8.8% and 12.8%). Therefore, the data indicate a difference in prevention strategies could be designed for these two groups of youth.

Figure 1.7: Percent of High School Students Who Planned to Attempt Suicide by Gender and Grade (2015)

Ethnicity	Gender	Grade				All High School	Overall
		9th	10th	11th	12th		
Native Hawaiian	Female	22.5	23.3	14.9	16.1	19.6%	16.7%
	Male	13.0	16.5	14.0	8.4	14.0%	
Non-Hawaiian	Female	20.3	20.0	15.2	16.1	18.2%	15.0%
	Male	8.3	11.3	14.8	13.1	11.6%	
State	Female	21.5	20.5	15.6	16.4	18.8%	15.6%
	Male	9.3	13.0	14.6	11.7	12.1%	

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Youth Risk Behavior Survey (YRBS).

SUICIDE

As this is a major transitional time for young adolescent girls, it is expected that there would be increased risk of mental health problems among this population. At this stage of development, not only are there physical changes, but also mental and emotional ones. Evidence has shown that suicide is a leading cause of death for young girls ages 15 to 19. According to the World Health Organization (2014), adolescent girls living in Europe and the Americas are twice as likely to commit suicide than boys. The difficulty that arises is the lack of data being collected on the issue of suicide in general. Many organizations do not assess or report any suicide related data, which results in stigmas and barriers associated with accessing necessary resources and supports for prevention.

Factors such as socioeconomic status, bullying, and exposure to violence or unstable social environments play large roles in adolescent mental health (World Health Organization, 2009). In the U.S., numerous adolescent girls reported experiencing bullying, whether electronically or physically at school, at higher rates than U.S. boys. Additionally, U.S. highschool girls were more likely to report feeling sad or hopelessly across all states than boys. Not surprisingly, the data also demonstrated that high school girls were more likely to contemplate, consider, plan, and attempt suicide (Kann et. al, 2015). By

addressing the numerous stressors that impact mental and emotional development of adolescent girls, we are looking to improve mental health status for their futures.

According to the National Vital Statistics Reports, in 2015, suicide was the tenth leading cause of death in the United States and the second highest cause of death among both males and females ages 15–19 years of age (Heron, 2017). In Hawai'i, suicide is listed as the number 10 leading cause of adult death; however, Native Hawaiians have a higher suicide attempt rate than all other ethnic groups. Although males have a higher rate of suicide completions, females attempt suicide at a higher ratio of three to one (Liu & Alameda, 2011).

Factors that contribute to a higher risk of suicide thoughts and attempts among Native Hawaiian young adults included depression, substance abuse, cultural identity, socio-economic status and significant life transitions (i.e. middle school to high school, high school to adulthood) (Balis & Postolache, 2008; Leong & Leach, 2010; Liu & Alameda, 2011). More Native Hawaiian females in public high schools (24.1%) seriously considered attempting suicide compared to non-Hawaiian females (18.7%) and females statewide (20.1%). Further, more Native Hawaiian females (14.6%) admitted to actually attempting suicide than non-Hawaiian (9.9%) and overall statewide females (11.0%).

Figure 1.8: Percent of High School Students Who Have Actually Attempted Suicide by Race and Grade (2015)

Ethnicity	Gender	Grade				All High School	Overall
		9th	10th	11th	12th		
Native Hawaiian	Female	16.4	19.4	8.8	12.8	14.6%	14.1%
	Male	9.9	11.0	16.1	14.6	13.2%	
Non-Hawaiian	Female	14.8	8.2	9.4	6.6	9.9%	9.0%
	Male	7.0	5.2	10.6	8.3	7.9%	
State	Female	14.9	10.4	9.7	8.0	11.0%	10.5%
	Male	8.1	6.8	12.0	9.3	9.3%	

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Youth Risk Behavior Survey (YRBS)

TREATMENT

In 2015, 4.2% of Native Hawaiian females who attempted suicide had to be treated by a doctor or nurse compared to non-Hawaiian females (2.7%) and females statewide (3.1%). Among those, there were more than twice as many 10th grade Native Hawaiian females who required treatment after attempting suicide (7.6%) than non-Hawaiian females (2.7%) and females statewide (3.6%). This number drastically decreases to 1.4% in the 11th grade for Native Hawaiian females—which is less than half of all females statewide (2.9%)—however, non-Hawaiian female students continue to increase to 3.5%. These attempt treatments could vary for result of an injury, poisoning, or overdose.

However, Native Hawaiian males in 11th grade were treated at a 150% higher rate than wāhine in the same grade. Kāne in 12th grade received treatment for suicide attempts 50% more than 12th grade wāhine.

In examining the difference between suicidal ideation, to creating a plan, to attempting suicide, to receiving treatment for a suicide attempt, patterns arise that should not be ignored for the mental and emotional health for ōpio in high school. It is imperative they receive support for what the factors that contribute to their sadness, hopelessness, and depression.

Mākua

For mākua aged Native Hawaiians from 2012 to 2016, nearly one in five wāhine considered their mental health “not good” for one to six days of the month (19.3%). When analyzing the rates for one to two weeks every mahina cycle, Native Hawaiian women would rate their own mental health combined as needing to improve 67% more than non-Hawaiian females (8.2% vs. 4.9%). This is an increase of 33.3% compared to non-Hawaiian adult females for the same time period and duration. During these same years, kāne had the highest rates when their mental health were considered “not good” for 14+ days of the month (13.0%). The second highest rate, of more than two weeks per month, were wāhine at 11.1%. Among kāne, this is more than a 71% increase compared to non-Hawaiian males (7.6%) for 14+ days when their perceived their mental health poor.

Among Native Hawaiian adults from 2012 to 2016, wāhine had the highest rates in the state while considering their combined physical and mental health were “not good” for 7 to 13 days of the month (11.2%). This means for one to two weeks every mahina cycle, Native Hawaiian women would rate their own physical and mental health combined as needing to improve. This is an increase of 33.3% compared to non-Hawaiian adult females for

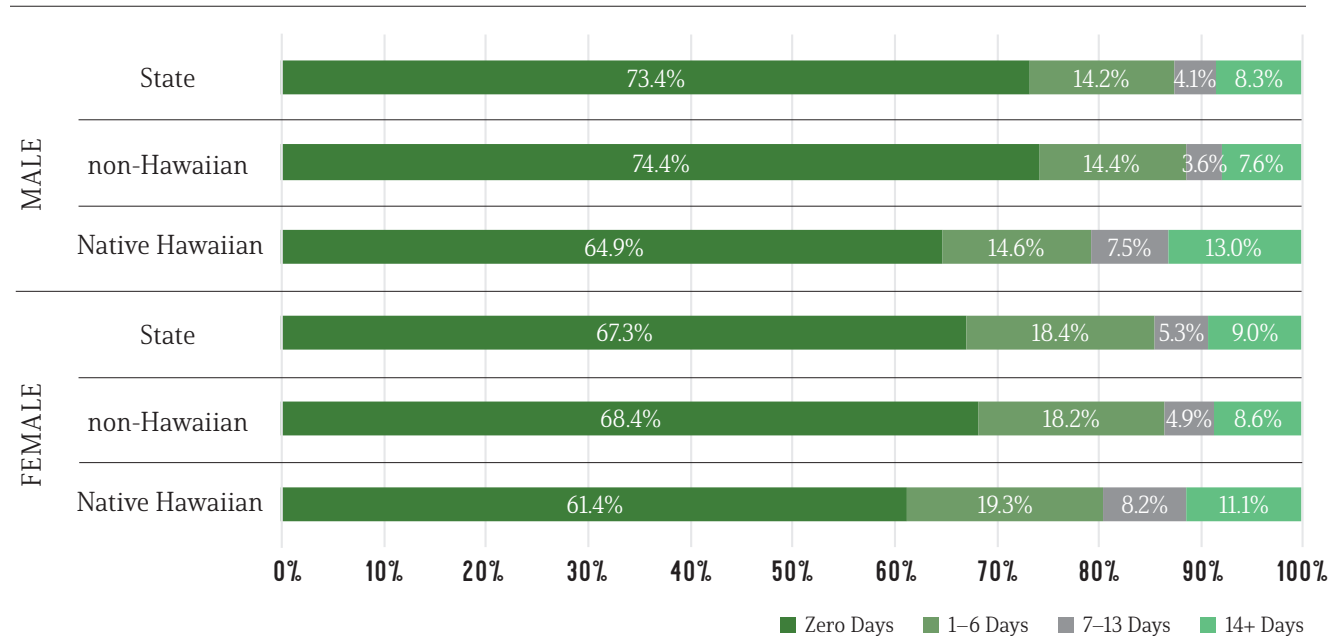
Figure 1.9: Percent of High School Students Who Have Received Treatment for Suicide Attempt (2015)

Ethnicity	Gender	Grade				All High School	Overall
		9th	10th	11th	12th		
Native Hawaiian	Female	4.3	7.6	1.4	2.5	4.2%	5.0%
	Male	3.5	4.5	9.4	4.2	5.3%	
Non-Hawaiian	Female	3.4	2.7	3.5	1.2	2.7%	2.8%
	Male	1.9	2.9	4.7	1.3	2.9%	
State	Female	3.6	3.6	2.9	1.8	3.1%	3.4%
	Male	2.3	3.4	6.0	1.8	3.5%	

Note: Ethnicity = DOH Race/Ethnicity

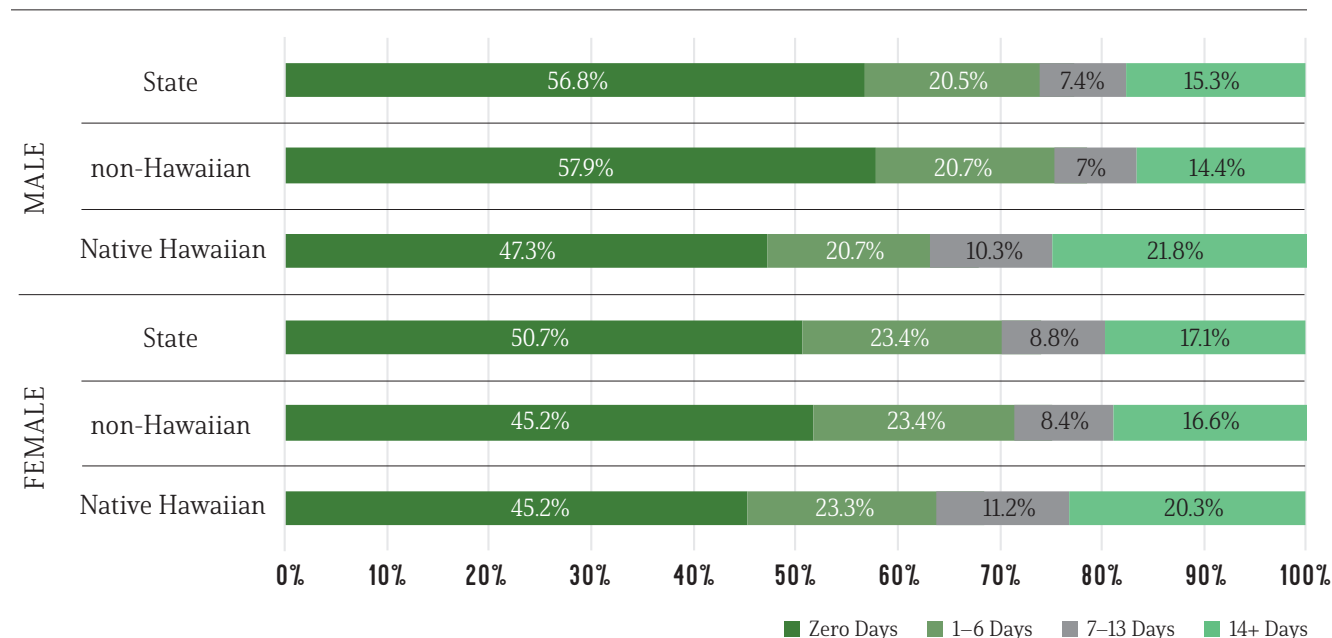
Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Youth Risk Behavior Survey (YRBS)

Figure 1.10: Hawaiian 30 Day Mental Wellness Rates by Gender (2016, 2015, 2014, 2013, 2012)



Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS)

1.11: Hawaiian 30 Day Physical & Mental Wellness Rates by Gender (2016, 2015, 2014, 2013, 2012)

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS)

the same time period and duration. During these same years, kāne had the highest rates when their physical and mental health were considered “not good” for 14+ days of the month (21.8%). The second highest rate, of more than two weeks per month, were wāhine at 20.3%. This is a nearly a 25% increase compared to non-Hawaiian adult females (16.6%) for the same time period and duration. Among kāne, this is more than a 50% increase compared to non-Hawaiian males (14.4%) for 14+ days when their perceived their physical and mental health poor.

Kūpuna

Projections by the Hawai'i State Department of Business Economic Development and Tourism (DBEDT) show the population of Hawai'i, 65 years of age and older, is estimated to increase from 14.5% in 2010 to 23.6% in 2040 (Hawai'i State Department of Business Economic Development and Tourism, 2012). However, in this same period, among Native Hawaiians 65 years of age and older, the population is estimated to decrease from 7.3%

in 2010 to 6.8%, with females continuing to represent a majority of that population (Kamehameha Schools, 2014). Depression is the most common mental illness in the elderly, affecting over 18% of the population 65 years of age and older (National Alliance on Mental Illness, 2009; (Sözeri-Varma, G. 2012).

Studies have shown that elderly experiencing depression function comparatively or worse than those with chronic health conditions (i.e. heart and lung disease, hypertension, arthritis and diabetes). Key predictors of elderly depression include bereavement; being single or widowed; sleep disturbance; physical illness, diseases and disabilities; medication; history of depression; and female gender (Cole, Martin, Nandini, & 2003; Leong & Leach, 2010).

Among elders, mental health status is surveyed according to duration of days. Native Hawaiian kūpuna kāne and wāhine have the most days in the month when they felt their mental health was poor. This included stress, depression, and problems with their emotions. When asked about their mental health in the 30 days preceding the survey, 11.5% of Native Hawaiian females stated

that their mental health was not good for 14 or more days during the month. Kāne were even higher at 12.7% (Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS)).

9.1% of Native Hawaiian kūpuna females (compared to 8.5% non-Hawaiian females) responded that a doctor or other health professional has told them that they have a depressive disorder including depression, major depression, dysthymia, or minor depression. However, kūpuna kāne report the highest rates of depressive disorder in the State, at 9.6%.

Figure 1.12: Kūpuna Depressive Disorder (2011–2015)

	Male	Female	Overall
Native Hawaiian	9.6%	9.1%	13.4%
non-Hawaiian	7.2%	8.5%	10.8%
State	7.4%	8.5%	11.2%

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS)

Interventions & Recommendations

It is common for women in lower socioeconomic groups to have psychiatric disorders due to the multiple stressors from poverty. Also, most women who are in poverty or homeless have a history of childhood physical abuse, sexual abuse, or both and more recent partner violence. The article, “Prevalence of Mental Health and Substance Use Disorders Among Homeless and Low-Income Housed Mothers,” focused on an increase in

mental illness and homeless among women. Homeless women, in particular, have higher rates of schizophrenia, bipolar disorder, and substance use disorder.

While women do experience high rates of mental illness, mothers, in particular, have higher rates when compared to other women. Depression is high among women who are in a financially strained environment while raising young children with little to no support. Caregiving responsibilities, trauma, and multiple forms of burden (social, mental, emotional, financial) are associated with mental health rates for women.

Women experience more stress than men do, and it influences longevity. Social support has a positive impact on women's health by providing “stress-buffering” properties. In addition, key interventions for vulnerable points in a wāhine's life can also make positive health differences.

Keiki and ‘Ōpio

- » Create improved mental health screening, school-based education that addresses mental health, and social supports for adolescent girls. Establishing “peer gatekeeper programs” can connect at-risk adolescents with the necessary help and resources.
- » Preventing self-harm ought to be addressed with gender-sensitive and grade-appropriate strategies for best-practice in public schools. School-based health centers with trained professionals can coordinate with high school staff and the community.
- » Schools who work with trained professionals in mental and behavioral health fields can serve as an important link with students and their families to ensure appropriate treatment and follow-up.
- » Provide an assessment of alcohol use and drug use disorders among adolescents, and improved education that addresses the risks and consequences for substance use and abuse.

Mākua

- » Provide caregiver support groups that allow women to come together, share their stories, and get necessary support and resources.
- » Enable access to a livable income that can support daily needs (housing, water, food, hygienic products, medicine, health care, etc.).
- » Address physical and mental health concerns in combination.
- » Create opportunities for mental wellness activities at least once every week.

Kūpuna

- » Promote building and maintaining healthy social relationships among aging women.
- » Continue mental health screening for seniors to detect symptoms of depression, such as loneliness.
- » Promote aging women's participation in the workforce, both formally and informally.
- » Establish social support systems offered through social services for kupunahine. The establishment of buddy systems or social support systems would decrease the risk of depression in aging years.
- » Integrate child care and adult day care. Studies in other countries and states have shown improved mental outcomes for elderly when they interact with children.

Dr. R. Mahana Chang, Psy.D.: Holistic Health for Mental Wellness

“For me, emotional health means learning how to embrace the spectrum of human experiences and emotions,” says Mahana Chang, a Licensed Clinical Psychologist who works for I Ola Lāhui and in collaboration with Kahuku Medical Center, in addition to her own private practice. “So many people grow up in households where only certain emotions can be expressed, and people become fearful of feeling.”

Born and raised in Kalihi, O’ahu, Chang is a 1998 graduate of the Kamehameha Schools. After Chang graduated from college and moved home in 2002, she became a skills trainer for children with autism. Eventually, her journey led her to earn her doctorate from Argosy in 2010. She’s worked with the Domestic Violence Action Center and several Native Hawaiian health organizations, including the Wai’anae Coast Comprehensive Health Center.

Chang was drawn to this practice by “the patients themselves,” she reflects. “It is a joy to see them on their journeys, becoming the people they are meant to become. Watching our capacity as humans to change and overcome is what has drawn me to it, and what keeps me passionate.” In her work in both rural and urban communities, most of her clients are women, and close to half her current case load is Native Hawaiian.



Greater awareness can work to rid of the shame and stigma that can bar people from getting help, and raise compassion to a level where functional support can be offered.

In her work, she has seen women who are working through issues such as domestic abuse, substance abuse, “women whose children have been placed with CPS (Child Protective Services), women in unhealthy relationships, who have gone through trauma. They are working to rediscover themselves, and have a new and healthy relationship with themselves and others,” Chang reflects. “It is hard work, and so much of it can be affected by psycho-social stressors. We definitely have to recognize the disadvantages some of these women come from—whether it’s a family history of violence or substance abuse, economic disadvantages—and address those things in the course of treatment in order for the whole person to be healthy.”

She feels it is important to work on issues of mental and emotional health holistically. “An integrative approach is necessary. When I work with a person, I also see if they have a parole officer, a CPS social worker or case manager—all the different components have to work in tandem, because these things are not isolated,” Chang says. In addition, she would like to see more financial resources that can help people with “a roof over their heads, medical access, food to eat—the appropriate, stabilizing resources that make it possible for people to not just survive, but be able to focus on doing the internal work that they need to do.”

In addition, Chang thinks more education about different kinds of abuse would be invaluable—not just in schools, but also in places that are supposed to help others, such as law enforcement and health care settings. Greater awareness can work to rid of the shame and stigma that can bar people from getting help, and raise compassion to a level where functional support can be offered. “Compassion is so important because it helps us reshape the conversation. Instead of asking a survivor of domestic violence, ‘Why did you stay so long?’ It’s, ‘What kept you from leaving?’ We need to be able to provide support that actually helps—and shame is an emotion that infiltrates our lives and impacts our ability to connect truly with ourselves and others. Even in Hawaiian culture, we need to look at and examine values that have been misinterpreted that can lend to the belief that doing for and focusing on self is wrong or selfish, and in turn, shameful.”

What Chang finds heartening in her clients is that “for many of them, this is the first time anyone in their family—not their parents or grandparents—are seeking treatment. When we look at Native Hawaiians, so many challenges they encounter are transgenerational. The women I work with are trying to break the cycles, to address issues, prioritize themselves, and be a positive shift for themselves and their families.”

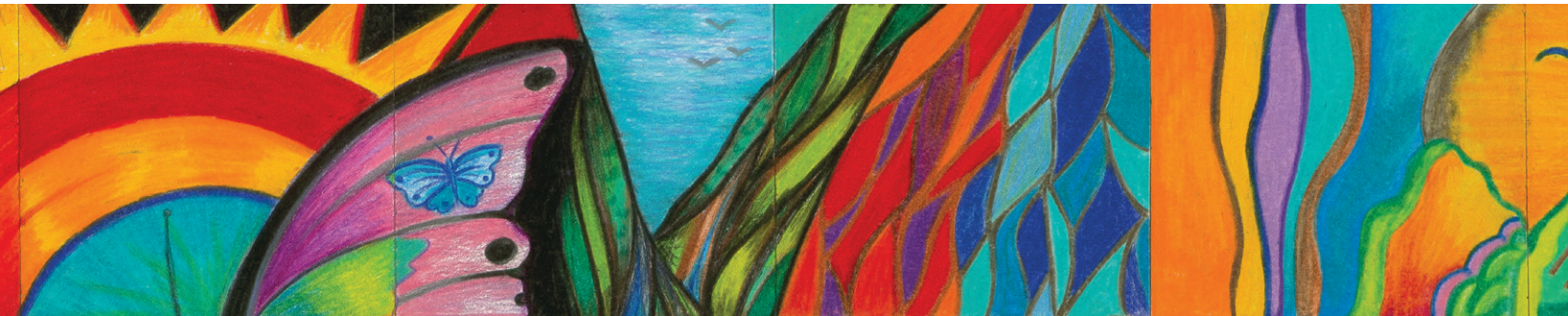
Physical Health

CHAPTER 2

E 'imi i ke ola mawaho.

Consult a kahuna to see what is causing the delay in healing.

Said when a person lies sick and recovery is slow. (‘Ōlelo No’eau, #311)



Issue Data for Intervention: Physical Health

- » 17.4% of Native Hawaiian public middle school female students do not have breakfast any day of the week.
- » 28.6% Native Hawaiian public high school female students have used electronic vapor products in the past 30 days.
- » Alarming, wāhine data indicates heavy drinking and binge drinking as alcohol behaviors are more than double non-Hawaiian females.
- » Obesity rates among wāhine are 20 percentage points higher than their non-Hawaiian female peers (37.7% vs. 17.6%).
- » The rates for breast cancer mortality from 2009–2013 were 134.4 (Native Hawaiian) and 14.5 (State of Hawai‘i).

Traditional Hawaiian Health and Maui Ola

Traditional Native Hawaiian understanding of health was served by a highly structured system of ancient medical art forms that included preventive health measures, acute care, and holistic healing. Mana was an important indicator of wellness in Hawaiian society, and the ways in which mana was transferred, maintained, depleted, and restored according to traditional customs and practices affected Native Hawaiian well-being. Indeed, health and prosperity were thought to be directly related to individual and collective mana (Crabbe et al., 2017). The flow of mana was considered to be vital to healing, particularly in the process of channeling mana as energy for the therapeutic benefit of a patient. The concept of *lōkahi* (harmony and balance) was an essential component of mana management, whether in the spiritual or natural state, and was particularly evident in the relationships maintained by a Native Hawaiian individual:

Harmony (*lōkahi*) is an important concept in the Native Hawaiian way. It is a state to be actively pursued in all realms of action and experience. A person knows when harmony (*lōkahi*) is present because they experience a special state of well-being characterized by the presence of energy and vitality. Thus, harmony (*lōkahi*) and life force (*mana*) are interdependent, and in their presence, person, family, nature, and spirit are one-unity. (Marsella, Oliveira, Plummer & Crabbe, 1995, p. 101).

The traditional healthcare structure, Ka 'Oihana Maui Ola, consisted of a vibrant population of healing professionals, comprehensive disciplines of medical and psychiatric care, and a wealth of ancestral knowledge diagnosing various illnesses toward reliable treatments (Fox, 2016). These concepts remain vital considerations in efforts to restore health and wellness in Native Hawaiians today.

Restoring wellness by rehabilitating mana requires a practitioner to master skills that consisted of therapeutic processes, causal recall of sickness, and application-appropriate remedies. The *kahuna kahiko* was respected for his many responsibilities as a “diviner, confessor, interpreter, intercessor, counselor, and exorcist, before he ever administered medicine. Healing the sick spirit, by restoring the depleted mana of an ailing patient, was the first step in therapy. When that was well begun, cure of the body would follow—if the god so willed” (Bushnell, 1993, p. 79). Through the application of practical skills and relevant religious knowledge, *kāhuna* maintained the socio-political-religious equilibrium of the *lāhui* and sustained Hawaiian society. These professions represent a critical part of the complex *kāhuna* structure that helped to build a thriving, healthy community because they harmonized the mana of the goddesses like Haumea with the chiefesses like Malaekahana and their descendants, such as Lā'ieikawai. According to Kamakau (1991), these orders were associated with gods and religious rites and entailed specific duties and roles which benefited all Native Hawaiians.

In healing practices, the masculine force of Kū was balanced by the feminine force of Hina. Native Hawaiians prayed to Kū and Hina as patron deities of medicine, especially when gathering healing herbs (Green & Beckwith, 1926, p. 201). According to historian and microbiologist Oswald Bushnell (1993), “Lono, Kū, and Hina, and to some extent Kāne, would remain through generations the constantly invoked gods of medicine” (p. 67). Sickness occurred in an individual because mana might have dissipated and need to be restored. This would result in an imbalance (*ma'i*) when these imbalances occurred, divine beings like Kū, Hina, Lono and *mo'o akua* were asked for their aid in the restoration of health and well-being (Fox, 2016). Sometimes this was through the use of herbal remedies and rituals prescribed by the healer. Other times this included emotional untangling between family members. Thus, spiritual wellness is central physical healing and to Hawaiian health beliefs.

Figure 2.1: Prayer to Maui Ola*

I Hiiaka—paha oe, i Hiialo i kakahiaka nei.
I ka laau a ke kaukau alii, i nui ke aho,
A hiki ia Maui-ola,
I ka heiau i Mahina-uli,
I ola ia Maui-ola.

*Perhaps thou are in Hiikua, perhaps in Hiialo, this morning.
Give virtue to the chief's medicine;
Grant him great vigor, and let him attain health,
To worship at the heiau of Mahina-uli.
Life through Maui-ola!*

*Note: Hi'iaka, hi'ikua, hi'ialo, hi'lani, hi'ilei symbolize love and affection and are often used interchangeably in poetry, songs, prayer and chant to describe kinship one bears (Pukui & Elbert, 2004).
(Malo, 1903, p. 147)

Healing Goddesses and their Significance in Spiritual Wellness

Specific supreme beings of healing, health, and medicine were well known among po'e Hawai'i during ka wā mamua. They were patron deities to the professionals that kept the lāhui healthy--the kāhuna lapa'au (medical experts). The presiding god of healing is Maui Ola, who is described as an akua known across Polynesia. He is described as "ka lā i ka maui ola," the sun at the source of life (Pukui & Elbert, 1986). Kānaka 'ōiwi have a saying or exclamation to someone who has sneezed: "Kihe a maui ola," sneeze and live. (Pukui & Elbert, 2003). Similarly, the Māori have a saying, "Tihe mauri ora!" which is spoken to a child who sneezes (Malo, 1903, p. 174). Even in small ways such as this that Hawaiian health was a constant act, and observed throughout daily life.

These healing akua were so important that they are immortalized today in oli, mo'olelo, ka'ao, and pule.

Maui Ola was invoked across the pae 'āina within the various classes, by kāne or wāhine. However, different goddesses were beseeched depending on specific geographic areas. Numerous supreme beings are found throughout traditional health practice, ceremonies, and places. In *Ka Nupepa Kuokoa* published on November 19, 1864 by S. K. Hukilani in Lahainaluna, Maui, he names specializations of Hawaiian gods and important forms they assumed (Na Akua O Koonei Poe I Ka Wa Kahiko, see Figure 2.2).

Figure 2.2: Na Akua O Koonei Poe I Ka Wa Kahiko (1864)

**Kumumanao.
NA AKUA O KOONEI POE I
KA WA KAHIKO.**

2. Na Akua wahine. He ekele mahele o na Akua wahine. 1. Na wahine i ka lua. Ua kapaia ia poe na wahine i ka lua, no ko lakou noho ana i ka lua, eia ko lakou mau inoa; o Pele, o Hiiaikaikapoli o-pele, o Hiiaikaipuasensena, o Haumea; a he nui aku no. 2. Na wahine i ka wai. No ka noho ana o keia mau Akua wahine i ka wai, eia ko lakou mau inoa i kapaia i na Akua wahine i ka wai. Eia ko lakou mau inoa, o Kihawahine, o Laniwahine, o Hinalelohia, o Lāieikawai, o Lāielohelohe, a pela'ku no. 3. Na wahine noho mauna. Eia na inoa o na Akua wahine e noho ana i ka mauna, o Poliahu, o Lilinoe, o Lanihuli, o Hapu'u, o Kala'iohauola, a me na mea like he nui aku no. E hootahua iho i ko lakou noonoona ka mahele akolu, a e hoouhi i ka noonoona.

He describes three main divisions of Hawaiian gods:

1. Nā Akua Kāne, or the male gods;
2. Nā Akua wāhine or the female gods; and
3. Nā akua 'oko'a, or the other gods.

Within the nā akua wāhine category of, the division of categorical deities can be defined further:

- a. Nā wāhine i ka lua or, the women of the volcanic pit. These were called the “women of the pit” because this was the place in which they lived. He lists this category to include: Pele, Hi'ikaikapoliopole, Hi'ikaikapua'ena'ena, Haumea, and many more.

- b. Nā wāhine i ka wai, or the goddesses of the water because they dwelled near the water, called Women of the Water, naming: Kihawahine, Laniwahine, Hinalelohia, Lāieikawai, Lāielohelohe, and so on.
- c. Nā wāhine noho mauna, or the goddesses of the mountain are named as: Poliahu, Lilinoe, Lanihuli, Hapu'u, Kala'iohauola, and many more like them (HEN: Thrum #16).

According to oral histories, Hi'iaka herself was the daughter of Haumea and Kāne who then became a patron of hula, oli, volcanoes, sorcery and medicine (Kalākaua, 1888; Beckwith, 1940). The crater at Kilauea is named Hi'iaka and consecrated as one of her domains of expertise on Hawai'i Island (Pukui, Elbert & Mo'okini, 1974). Another deity was La'auli, a female god of medicine associated with Kāne on the island of Moloka'i. She was worshipped by wāhine in the hale noa (Malo, 1903). Another archetype is Hina'ea, goddess of sunrise and sunset, healer, and expert kapa maker with kapa stamps. She sometimes took the kinolau form of lele bananas (Pukui & Elbert, 1964).

These healing akua were so important that they are immortalized today in oli, mo'olelo, ka'ao, and pule.

To know these akua wāhine by name and characteristic honors the highest quality of traditional practices of Hawaiian health and medicine. Kāhuna methodology of treatment required detailed prayers in their name and honor for the best remedy to be successful. Margaret Kalehuamakanoelu'ulu'uonāpali Machado, master and kumu was a highly respected kūpuna wahine in Kona, who always noted in her teachings that healing begins with pule (Chai personal communication, 2016). These pule were often very robust and had many levels of meaning. It was the use of their inoa by haku wāhine that they have been preserved through oral history, continuing traditional practices, and scholarship of Hawaiian history that we can recount these sacred names and their role in the physical health and wellness of po'e kahiko in ka wā mamua.

EVERYDAY HEALTH: FOODS AND PHYSICAL ACTIVITY

‘Ai (food) often refers to poi in historical literature; poi being the Hawaiian food staple consumed by all kânaka throughout time beginning with fundamental principles of Hawaiian ancestry. Kalo was cultivated in Hawai‘i to a degree unseen in any other part of the world (Handy, Handy & Pukui, 1972), where the corm, lū‘au (taro leaves), and hā (stalk) were eaten. More importantly, Kalo is spiritually nourishing because of the origin of our people through Hāloa. The everyday consumption of kalo is vital to the healthy connections made when nourished by our first foods. The first kalo plant grew from the body of Hāloa, the first born of Papa and Wākea, two preeminent akua who dwelled in Hawai‘i. The second child, Hāloanakalaukapalili was the first kanaka, and from him came the Hawaiian people. Practices of ‘ai were ceremonial as well as universal. Traditional foods were cultivated in māla (gardens), eaten together by ‘ohana in the hale ‘aina (eating house) setting, but could also be found in healing heiau (structure dedicated for worship) for their medicinal properties. In addition to kalo, other vegetables that were commonly consumed by wāhine were ‘uala (sweet potatoes), palula (‘uala leaves), uhi (yams) and the iholena and pōpō‘ulu varieties of mai‘a (bananas).

The primary protein source was i‘a (fish). Customarily, i‘a were caught in the deep oceans by the kâne and the nearshore by wāhine but eaten by both. Spiritual connections with the sea was common during the traditional era, for instance, wāhine prayed to Hina‘ōpūhalako‘a, goddess of corals and spiny sea creatures, where they would collect limu (edible seaweed) (Beckwith, 1970). Fish were also raised in loko i‘a (fishponds) which were essential to community abundance and district distribution practices. Pork (pua‘a) was consumed by wāhine only in certain ceremonies. ‘Ilio (dog) was favored above both pork and chicken, but was restricted to wāhine (Titcomb, 1969). Many birds that are endemic or indigenous to Hawai‘i were in fact eaten in ka wā kahiko such as nēnē (Hawaiian goose), o‘o (black honeyeater), mamo (black Hawaiian honeycreeper) and ‘amakihi (Hawaiian honeycreeper) (Malo, 1903). If a woman was sick, she was denied ananalo (a variety of the hinalea or coral fish) and olali (a coral reef fish) by the kahuna (Malo, 1903).

In addition to the work required of everyday life in ka wā kahiko, wāhine also engaged in sports, such as surfing, a sport often enjoyed by ali‘i wāhine. Keleanuino‘ana‘api‘api was an ali‘i wāhine known for surfing at Hamakuapoko, Maui (Kamakau, 1991). The goddess Hina, “mother of Maui, dreams in Kahiki of surf riding at Wailua on Kauai with a handsome man: (Beckwith, 1970, p. 231). Wāhine also maintained physical strength in order to engage in warfare. Mānono was a fearless fighter who battled alongside her kâne, Kekuaokalani, in the battle of Kuamo‘o. Also, in the battle between Kumuhonua and Haumea at Kualoa, the wāhine fought with kukui nuts, which led to Kumuhonua’s defeat (Poepoe, 1906). Ka po‘e kahiko took good care of their health and lived to be very old. Mary Kawena Pukui once interviewed a wāhine from Maui who was 115 years old due to everyday healthy living (Pukui, 1942).

RESTORING HEALTH

Physical well-being was established from pre-conception until death through dozens of practices including but not limited to: mea‘ai (food), la‘au lapa‘au (herbal medicine), balance within ‘ohana (ho‘oponopono), and the physical manipulation of the body and its ‘iwi (lomilomi). Expecting mothers observed a restricted diet during and after pregnancy, and the child was fed foods that nourished their bodies throughout adolescence and adulthood. Kāhuna lapa‘au (medicinal experts) maintained and restored health through spirituality and expert use of the natural environment. And at death, the body was cared for and the ‘uhane (soul) traveled to the ao aumākua (realm of family guardians).

Restorative health practices were serious among kânaka ‘ōiwi, and were well known by ali‘i, kāhuna, and maka‘āinana alike. Experts healed patients with their spiritual connection, but so did certain places with restorative mana. “Sick people are sometimes brought to a cave near the place where stands Kumauna and left here overnight for healing. Kumauna is one of the forest gods banished by Pele. He is said to have lived as a banana planter in the valley above Hi‘ilea in Ka-u district

on Hawai‘i which bears his name” (Beckwith, 1970, p. 17–18). Kāhuna lā‘au lapā‘au were experts in pharmaceuticals. They knew what plants to gather and combine for certain ailments and would oversee the treatment of the illness, and they “worshipped Ma‘iōla, Kapualaka‘i and Kaukaho‘ōlama‘i who were the goddess of women and those who healed” (Chai, 2005, p. 41). The treatment for kāne and wāhine also consisted of different lā‘au (Chun, 1994) because oftentimes, sickness affected females differently than males.

Within the lomilomi tradition, pule were given to female of divine mana, including the goddess of massage, Hamoea (Chai, 2005, p. 40). Lomilomi was used to reset bones and realign the body. “The name Hamoea can be translated as hama, lit. rub gently,” and ea, “spirit” (Andrews Dictionary). Literally “spirit massage,” it may imply that the spirit gives massage, that the spirit is in massage, and that massage restores the spirit” (Chai, 2005, p. 42).

Sickness was not simply physical to the ailing. Internal family conflicts could manifest as illness, usually in the weaker family members, such as children. These issues were resolved through ho‘oponopono, a cleansing of emotional entanglements through family meetings that involved pule, discussion, confession, repentance, and mutual restitution and forgiveness (Pukui, Haertig, & Lee, 1972). The practice of ho‘oponopono was integral in this cooperative approach towards a comprehensive healthcare system. It contributed to maintaining balance by addressing the cognitive and psycho-spiritual nature of multiple individuals and by establishing clear lines of communication for clear expression. At the individual level, the mind is eased through the balance of the ‘uhane and the body to reach a state of pono (Paglinawan & Paglinawan, 2007). Ultimately, this process resulted in a well ‘ohana and a Hawaiian society working in lōkahi.

‘AI KAPU AND ‘AI NOA

The ‘ai kapu refers to the set of practices and restrictions that surrounded food and eating in ka wā kahiko. Under the ‘ai kapu, men prepared the food for their families, and cooked meals for men and women in separate imu. Separate utensils were used by men and women in

both the preparation and consumption of food. Certain foods were restricted to women, such as red fish, pork, and other kinolau (physical manifestation) of the male akua, such as Kū or Kāne. Religious exceptions to this included the kalahu‘a or the religious ceremony that allowed women to eat fish after the kapu during makahiki (Malo, 1903).

Hawaiian historian, Dr. Lilikalā Kame‘eleihiwa (1992), interpreted the ‘ai kapu, which originated with Papa and Wākea (the progenitors of the Hawaiian people), as a metaphor of the “separation of male kapu from the female defilement” (p. 36). She explained that if women were allowed to eat restricted foods, it would be a symbolic usurpation of the mana of those male gods whose kinolau (earthly body forms) are those foods. Through protocol like the kapu system, mana was maintained for both men and women.

Following Kamehameha’s death, ali‘i engaged in ‘ai noa (eating without observing kapu), where men and women were allowed to eat together (Kamakau, 1996). Some accounts noted that the breaking of the ‘ai kapu was punishable by death (Handy & Pukui, 1972); however, it was customary following the death of a high-ranking ali‘i that the chiefly court had ‘ai noa while in mourning, and women entered heiau and ate foods that were otherwise restricted, including mai‘a, niu, and pig (Kamakau, 1996). This practice of ‘ai noa was only done amongst the ali‘i, and was not observed by the maka‘āinana (Ibid).

During the mourning of Kamehameha, Kekuaokalani and Liholiho left Kona so the new mō‘i would not be defiled by Kamehameha’s death. However, two wāhine of Kamehameha, Ka‘ahumanu and Keōpūolani, refused to reinstate the ‘ai kapu. Keōpūolani continued to eat with her son, Kauikeaouli. Kekuaokalani tried to convince his cousin, Liholiho, not to return to Kailua, lest he participate in the ‘ai noa. Liholiho did return, and he ate food with his mother and declared the ‘ai noa (Kamakau, 1996). Warfare then ensued between the two sides, Kekuaokalani on the side of the ‘ai kapu, and Kalanimoku on the side of the ‘ai noa. They fought in the battle known as Kuamo‘o, where Kekuaokalani was defeated. Ka‘ahumanu followed with the denouncement of the old religion and the tearing down of heiau.

Transformations of Health and Health Care

In addition to changes in diet and lifestyle, one of the greatest social transformations was the introduction of foreign disease. In 1778, there were estimated upwards of a million Native Hawaiians in Hawai‘i. Illnesses brought by foreigners—to which ka po‘e kahiko had no natural immunity—decimated nearly 90%–93% of the Native Hawaiian population in the 100 years following Western contact (Blaisdell 1998, Stannard, 1989, Malo 1898, Schmitt 1970, Chun 1994, Kamakau 1961, Osorio 2002, Schmitt and Nordkye 2001). Kūpuna called these new diseases “ma‘i malihini” or foreign illness, including cholera, syphilis, tuberculosis, smallpox, and Hansen’s disease (Kamakau 1991; Bushnell 1993; Pukui, Haertig & Lee 1972; Fox, 2017).

“Ma‘i pālahalaha (infectious disease) shaped new biomedical classification during the complicated history that introduced Native Hawaiians with foreigners from Europe, America and Asia in the 1800’s” (Fox, 2017, ii). With little immunity to foreign pathogens, Hawaiians experienced severe depopulation caused by these ma‘i pālahalaha, and also severe disconnection from their traditional ways of health, medicine, and healing (Ibid). These introduced diseases disconnected kānaka ōiwi from Ka ‘Oihana Maui Ola and brought tremendous disorder in Hawaiian history (Fox, 2016).

In response to this health crisis, the ali‘i fought to save the lives of their people through the establishment of hospitals. Queen Emma and King Kamehameha IV, Alexander Liholiho, personally raised funds door-to-door, and, with support from the Hawaiian Kingdom Government, established the Queen’s Hospital which opened in 1859. In 1890, Queen Kapi‘olani, wife to Kalākaua, raised money to establish the Kapi‘olani Maternity Home (now known as Kapi‘olani Medical Center) to provide healthcare to women (Kapi‘olani Medical Center Website). Both of these hospitals exist today in Honolulu and are major legacy institutions to health care in Hawai‘i.

HEALTHY LIFESTYLES

Establishing healthy lifestyle choices and habits at a young age—such as diet, exercise, and avoiding substance use—can promote healthy transitions from youth to adulthood, especially among girls. Healthy eating behaviors must start very young (before age 3), and continue through elementary to high school, and into adulthood. 15.1% of Native Hawaiian female students in public high schools do not have breakfast any day of the week (YRBSS, 2015), and neither do 17.4% Native Hawaiian female students in public middle schools. When surveying Native Hawaiian public middle school female students, 23.3% consumed five or more fruit/vegetables per day during a seven-day period (YRBSS, 2005). Comparatively in 2015, only 17.1% of Native Hawaiian female students in public high school consumed five or more fruit/vegetables per day during the past seven days. Further, data indicate that only one in five Native Hawaiian adult women consume less fruits and vegetables per day as part of their nutritional intake (BRFSS, 2015).

Data has shown that adolescents that are more physically active have healthy behaviors, while physically inactive youth have increased trouble controlling anxiety and depression (World Health Organization, 2009). It is important to create environments that promote healthy lifestyles to ensure health transitions for kaikamahine, because merely one in five of Native Hawaiian adult females report doing enough physical activity to meet the aerobic and strengthening recommendations (BRFSS, 2015). 24.7% of female Native Hawaiian public middle school students were physically active for a total of 60 minutes or more per day on all of the past seven days, compared to 19.8% of female Native Hawaiian public high school students (YRBSS, 2015).

Many countries worldwide are seeing an increase in obesity rates among young girls, as this population participates in physical activity at lower rates each year. Data indicate that 8.5% of Native Hawaiian females in middle school are obese (YRBSS, 2005), as are 9.5% of Native Hawaiian females in high school (YRBSS, 2015). There are many external factors that affect these outcomes, such as unsafe environments or lack of access, but the implications of limited exercise and poor diet from an early age can be detrimental: studies have shown that obese adolescent girls often carry their obesity into adulthood,

Figure 2.3: Percent Alcohol Behaviors Among Native Hawaiian Public School Females (2015)

Alcohol Behaviors	Middle school students	High school students
Ever drank alcohol	37.8	62.4
Had their first drink before age 13	29.2	24.1
Engaged in binge drinking within the past 30 days	8.9	19.6
Consumed alcohol within the past 30 days	17.1	30.9
Have consumed alcohol or marijuana within the past 30 days	23.3	39.0

Source: Hawai'i Health Data Warehouse. (2017). YRBSS.

which should draw our attention to lifelong behaviors. Female BMI in the State increased from 2015 to 2016 by 1.7%; however, for wāhine, it increased 4.7% (BRFSS, 2016).

This report notes that there are numerous factors that influence healthy lifestyles among women and girls, and that these indicators are but a few among many. Historical insight of healthy Hawaiian activities creates a picture of daily life in Hawai'i and can serve as goals to integrate into health and health care.

SUBSTANCE ABUSE

Globally, there appears to be increased substance use among adolescent girls, and more young girls are beginning to consume alcohol and use tobacco at higher rates (World Health Organization, 2009). In the US between 2002 and 2012, girls between the ages of twelve and seventeen had similar or higher user rates of alcohol and psychotherapeutics than their male counterparts. This pattern is also seen in terms of tobacco use among United States adolescents. Data from 2012, showed that 44% of girls who consumed alcohol in the past year had a depressive episode, while 24% and 16.1% who used marijuana and psychotherapeutics, respectively, had episodes of major depression (Amatetti, 2014). The psychoactive effects of drugs and alcohol can be experienced at higher levels among girls, due to their biological development, which can lead to negative consequences such

as “violence, unintentional injuries and vulnerability to sexual coercion” (World Health Organization, 2009, 32). Alarming, wāhine data indicates heavy drinking and binge drinking as alcohol behaviors that are more than double non-Hawaiian females (BRFSS, 2015).

Substance use and abuse like alcohol, smoking, and drug use have been widespread among women in the United States. While this information is alarming many studies have looked into more details behind the reasons for women who have turn to substance use. Many women use substance as a relief for stress and a coping mechanism. Women who have experienced any type of abuse or assault as a child or adult will more likely turn to substance use as a coping mechanism. However, substance use has the potential to increase violence, abuse, and physical and sexual assault. One drink is equivalent to a 12-ounce beer, a 4-ounce glass of wine, or a drink with one shot of liquor. A heavy drinker is a woman who drinks more than one drink daily. Native Hawaiian females increased their heavy alcohol consumption from 7.4% in 2012 to 8.6% in 2014. This equates to thousands more wāhine who are heavy drinkers in four years. Comparatively, during this same time period, heavy consumption of alcohol among women in Hawai'i increased from 5.6% in 2012 to 6.4%, or 3,200 more women in the State who are heavy drinkers in four years. The 2015 data in this table show the difference between amount and frequency of alcohol consumed by gender.

Figure 2.4: Percent Drug Use Among Native Hawaiian Public School Females (2015)

Drug Behaviors	Middle school students	High school students
First used marijuana before age 13	12.9	14.3
Used marijuana in the past 30 days	14.1	27.4
Ever sniffed glue, breathed the contents of aerosol spray	7.0	9.0
Ever used ecstasy (also called MDMA)	1.3	5.4
Ever used some form of cocaine, including powder, crack, or freebase	1.7	3.5
Have used methamphetamines (also called speed, crystal, crank, or ice)	1.8	3.1
Taken a prescription drug such as OxyContin, Vicodin, tranquilizers, Valium, Xanax, or Ritalin without a doctor's prescription	4.8	12.0
Never used any illicit drugs (marijuana, crack, other forms of cocaine, heroin, or use of other opiates, stimulants, barbiturates, or tranquilizers, Valium, Xanax, or Ritalin) without a doctor's prescription	83	62.8

Source: Hawai'i Health Data Warehouse. (2017). YRBSS.

SMOKING

Research has shown that though smoking rates have declined, young adults currently have the highest smoking prevalence rate of three age groups: youth, young adult, and adult. It is estimated that 27.7% of young adult females reported cigarette use (U.S. Department of Health and Human Services, 2014). More than 1/4 of Native Hawaiian females in public high school reported using electronic vapor products in the past 30 days. This is 4% more than Native Hawaiian female adults (23.6%). Surprisingly, adult Native Hawaiian males have the lowest e-cigarette or vapor use (26.5%) compared to non-Hawaiian males (35.4%) and the State rate (32.9%).

The Hawaii State Department of Health oversees The Pregnancy Risk Assessment Monitoring System. This surveillance surveys with mothers with a focus on indicators at risk. Information provided within the State of Hawai'i shows the percentage of Native Hawaiian women

who smoked pre-pregnancy as 25.8%, during pregnancy specifically in the last trimester as 9.4%, and postpartum smoking as 15.0% (PRAMS, 2010–2014).

ILLNESSES AND DISEASE

From 2012 to 2016, Native Hawaiian women were among the least likely to consider their physical health as “not good” for zero days of the month (63.1%). This means for every mahina cycle, nearly 2/3 of wāhine would rate their own physical health as needing to improve. During these same years, mākua kāne and wāhine had the highest rates of their physical health being “not good” for 14+ days of the month (11.8 and 11.3%). For kāne this is nearly a 36% increase compared to non-Hawaiian adult males (8.7%) for the same time period and duration. Among wāhine, this is about 18% higher compared to non-Hawaiian females (9.6%) for 14+ days when their perceived their physical health was thought to be not well.

CHRONIC DISEASE

Chronic diseases among Native Hawaiians have not continued to improve since the publication of the *Kānehōʻālanī: Transforming the Health of Native Hawaiian Men* (OHA, 2017). This updated report section includes a five-year aggregate and is highlighting slightly different conditions. In the most recent data available aggregated for five years of 2012–2016 in the BRFSS. The table here indicates that across six indicators, chronic diseases among Native Hawaiians have the highest rates compared to their non-Hawaiian counterparts. These five years in combination tell us that kāne continue to suffer the greatest burden of disease. Wāhine have a slightly higher rate of Type II Diabetes (11.2%), however, this falls in the same confidence range as kāne (11.0%).

Consequently, obesity stands out among all four comparison groups, where kāne and wāhine obesity are each more than double non-Hawaiian males and females. Therefore, obesity continues to be an area for prevention efforts, research, and planning in Hawaiʻi. Further, wāhine have strikingly higher rates of asthma at 22.2%. This is an increase of 70% than Native Hawaiian males, and an increase of 270% than non-Hawaiian males in the state. Therefore, work must be done to address asthma among wāhine.

When comparing Native Hawaiian females to non-Hawaiian females during the same years (2012–2016) and across chronic disease rates, we find important information for

Figure 2.5: Percent of Alcohol Behaviors Among Native Hawaiian Females and Males (2015)

Indicator	Female			Male		
	Native Hawaiian	Non-Hawaiian	State of Hawaiʻi	Native Hawaiian	Non-Hawaiian	State of Hawaiʻi
Current drinker*	42.5	43.0	43.0	54.8	61.3	60.5
Heavy drinker**	10.9	5.1	5.8	13.7	8.9	9.5
Binge drinker***	21.9	10.1	11.7	33.5	25.0	26.1

* At least one drink within past 30 days

** Women > 1 drink/day; men > 2 drinks/day

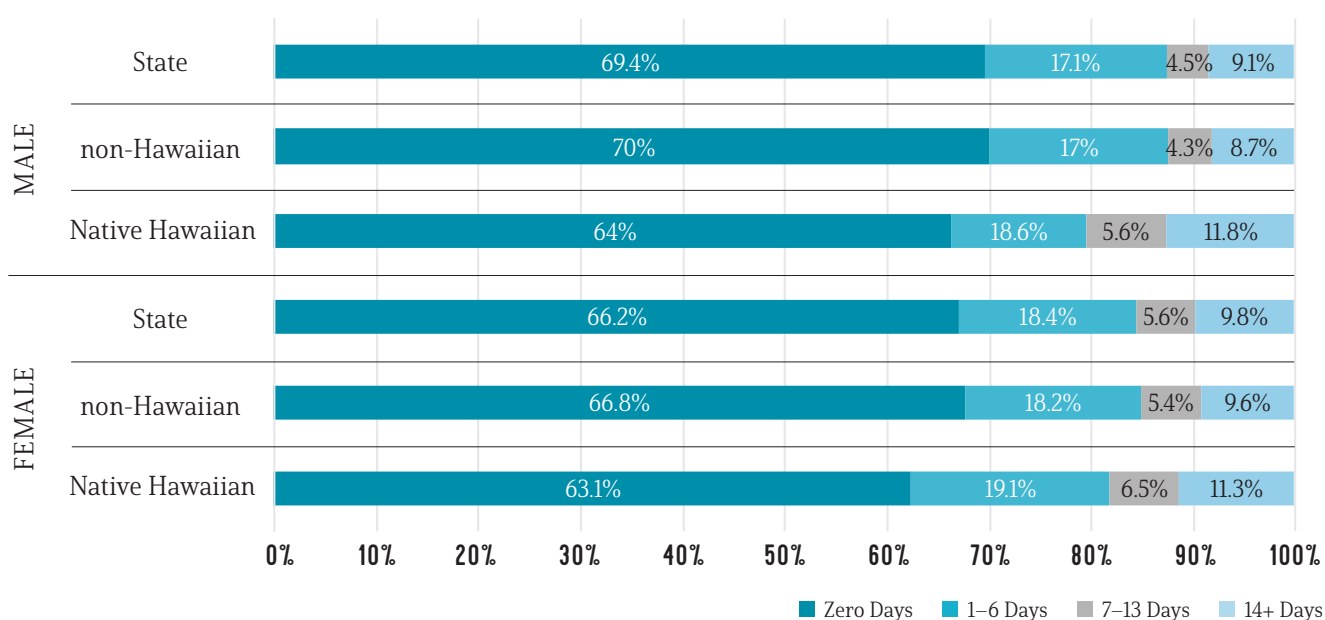
*** Women 4+ drinks on one occasion; men 5+ drinks on one occasion

Source: Hawaiʻi State, Department of Health. Hawaiʻi Health Data Warehouse. Behavioral Risk Factor Surveillance System.

Figure 2.6: Smoking Behaviors Among Native Hawaiian Public School Females (2015)

Smoking Behaviors	Middle school students	High school students
First tried cigarette smoking before age 13	8.6%	7.2%
Have smoked cigarettes in the past 30 days	7.4%	8.4%
Have used electronic vapor products in the past 30 days	22.9%	28.6%

Source: Hawaiʻi Health Data Warehouse. (2017). YRBSS.

Figure 2.7: Hawaiian 30 Day Physical Wellness Rates by Gender (2016, 2015, 2014, 2013, 2012)

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS)

Figure 2.8: Chronic Diseases among Native Hawaiians by Gender (2012–2016)

Race-Ethnicity	Gender	Type II Diabetes	Obesity (BMI>=30)	Heart Attack (ever)	Stroke (ever)	Smoker (current)	Asthma (current)
Native Hawaiian	Female	11.2%	37.7%	3.4%	3.7%	20.2%	22.2%
	Male	11.0%	46.7%	5.8%	3.7%	24.0%	13.1%
Non-Hawaiian	Female	8.5%	17.6%	2.1%	2.8%	9.9%	10.9%
	Male	9.1%	22.2%	4.1%	2.8%	15.2%	6.0%

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS).

intervention. Wāhine have higher rates for each condition compared to non-Hawaiian females. For example, wāhine have strikingly higher rates of asthma at 22.2%. This is an increase of 103% than non-Hawaiian females in the State. Also, double the amount of wāhine are current smokers compared to non-Hawaiian women. Finally, obesity rates among wāhine are 20% more percentage points than their non-Hawaiian female peers. According to the Behavioral Risk Factor Surveillance System (2016), in 2015 rates of Native Hawaiian females obesity by age group included 58.2% for wāhine ages 45–54 and 53.1% among ages 35–44.

CANCER

Each year from 2009–2013, approximately 6,700 Hawai'i residents were diagnosed with cancer, and more than 2,200 died from cancer, the second leading cause of death after cardiovascular disease (University of Hawai'i Cancer Center and Hawai'i Tumor Registry, 2016). The average annual incidence and mortality rates for all cancers were higher for men than women.

Among Native Hawaiian women, the five most common cancers were:

1. Breast (35.4%)
2. Lung and Bronchus (31.3%)
3. Uterus/Endometrium (8.8%)
4. Colon and Rectum (7.8%)
5. Leukemia (4.6%)

For Native Hawaiian women, the five leading causes of cancer mortality were:

1. Lung and bronchus (24.8%)
2. Breast (16.8%, 3)
3. Colon and Rectum (6.5%)
4. Pancreas (8.1%)
5. Ovary (4.5%)

(Source: Hawai'i State, University of Hawai'i, Cancer Research Center of Hawai'i, Hawai'i Tumor Registry, Hawai'i Cancer Facts & Figures 2010).

In Hawai'i, uterus/endometrium cancer incidence (40.4%) and mortality (9.1%) were both highest for Native Hawaiians (Hawai'i State, University of Hawai'i, Cancer Research Center of Hawai'i, Hawai'i Tumor Registry, Hawai'i Cancer Facts & Figures 2010).

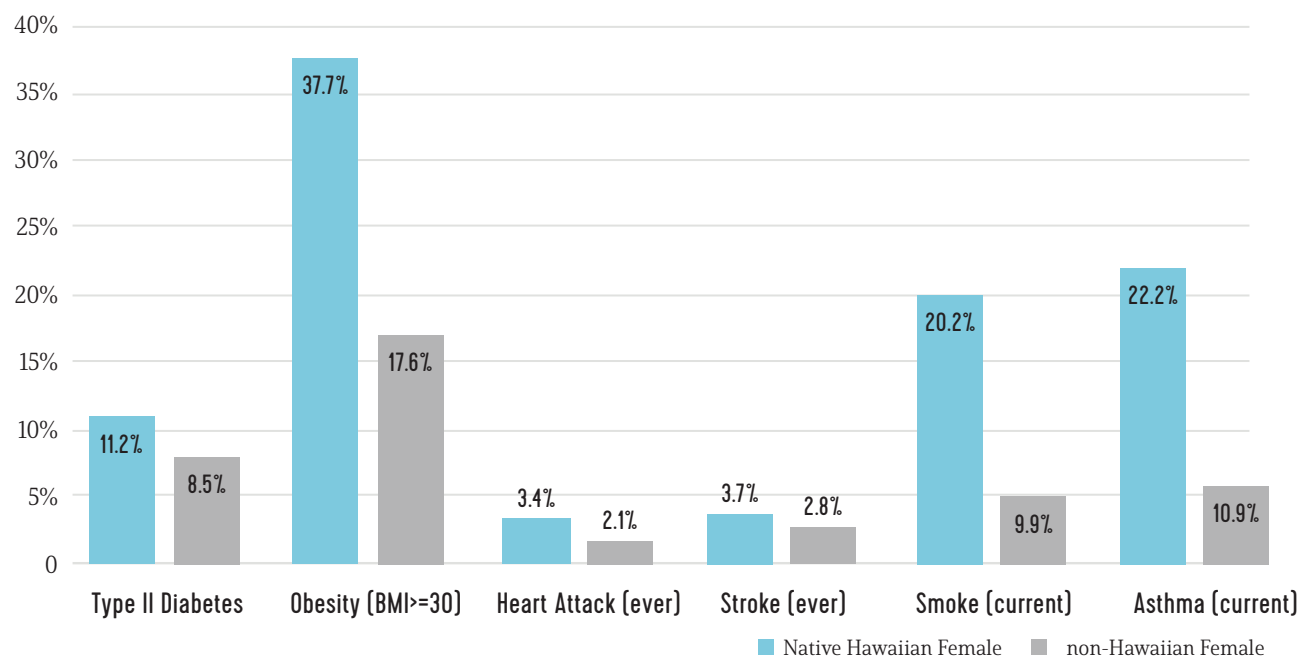
By race-ethnicity in Hawai'i, cancer incidence was highest for Native Hawaiian women, and cancer mortality was highest for Native Hawaiian men and women; the leading cause being lung cancer. In 2016, 21% of Native Hawaiian women ages 45–54 years had any type of cancer, twice the percentage for non-Hawaiian women. No data was available for Native Hawaiian women ages 35–44 years and 75+ years. When providing age-adjusted rates by gender, more than twice as many Native Hawaiian women (10.7%) had any type of cancer than Native Hawaiian men (4.9%) (BRFSS, 2017).

BREAST AND GYNECOLOGIC CANCERS

Looking at specific types of cancers, breast cancer is the most common cancer for women (33%). The average annual number of newly diagnosed invasive breast cancers was 1,107 and in situ non-invasive early stage tumors was 300. Invasive breast cancers have increased about 2% per year from 2004–2013. During the same period, invasive breast cancer mortality rates declined, with Hawai'i having the lowest mortality in the nation. The average annual number of deaths from breast cancer is 125 (12%).

Native Hawaiian women had the highest incidence (174.8) and mortality (134.4) for breast cancer (age-adjusted rates per 100,000) among White, Japanese, Chinese, Filipino, and Other race-ethnicities. The rates for mortality from 2009–2013 were 27.4 (Native Hawaiian) and 14.5, (State of Hawai'i), respectively (University of Hawai'i, 2016). Therefore, much more needs to be done with respect to breast cancer among Native Hawaiian females.

Figure 2.9: Chronic Diseases Comparisons Among Females (2012–2016)



Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS).

Figure 2.10: Comparative Cancer Rates (Any Type) by Gender (2016)

	Male	Female	Overall
Native Hawaiian	4.9%	10.7%	8.0%
non-Hawaiian	7.4%	9.3%	8.2%
State	7.3%	9.5%	8.3%
United States	—	—	6.7%

Note: **data not available.

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS).

Figure 2.11: Native Hawaiians Who Have Had Cancer By Age Range (2016)

	35–44	45–54	55–64	65–74	75+	Overall
Native Hawaiian	**	20.9%	13.8%	22.3%	**	10.2%
non-Hawaiian	6.1%	10.2%	14.1%	21.6%	19.8%	11.3%

Note: **data suppressed.

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS).

Figure 2.12: Breast Cancer Among Women by Indicator (2009–2013)

Indicator	Native Hawaiian Women	State of Hawai'i Women
Incidence	174.8	134.4
Mortality	27.4	14.5
Advanced Stage	32.6%	34.4%

Source: University of Hawai'i Cancer Center and Hawai'i Tumor Registry. (2016, December). Hawai'i Cancer at a Glance 2009–2013.

Native Hawaiian women had the highest Advanced Stage cancer rate, compared to White, Japanese, Chinese, and Filipino for the State.

The cancer-stage distribution for Native Hawaiian women were:

1. In situ 17.1%
2. Localized (no metastasis) 51.5%
3. Advanced 29.3%
4. Unstaged (no cancer, insufficient information) 2.1%

Early detection is key toward successful cancer treatment. The 2016 BRFSS provides the following mammogram and clinical breast exam data for tracking Native Hawaiian women screening in this area. For women age 40+ who had a mammogram within two years, the age breakdown for Native Hawaiian women and non-Hawaiian women, demonstrate that overall, 79% of Native Hawaiian women had a mammogram within two years, versus 76% of non-Hawaiian women. 89% of Native Hawaiian women

reported ever having a mammogram at any time, versus 93% of non-Hawaiian women. No data was reported for Native Hawaiian women age 70+. Data for women who had ever had a clinical breast exam (2015) indicate that 52% of Native Hawaiian women had clinical breast exams within one year. 17% of Native Hawaiian women had no clinical breast exam compared to 19% of non-Hawaiian women. This information indicates that slightly more Native Hawaiian women are getting CBEs than non-Hawaiian women.

GYNECOLOGIC CANCERS

When surveyed in the Behavioral Risk Factor Surveillance System (BRFSS) if they had ever had a pap smear, 87% of wāhine responded they had, compared to 85% of non-Hawaiian adult women (2016, age-adjusted). In 2016, 72% of Native Hawaiian women had a pap test within 3 years compared to 70% for non-Hawaiian women. 14% of both Native Hawaiian and non-Hawaiian women had no pap tests.

Figure 2.13: Female Pap Smear Comparison by Age Group (2016)

Age Group	18–24	25–34	35–44	45–54	55–64	65–74	75+	Total
Native Hawaiian	**	81.6%	82.4%	85.8%	61.2%	69.1%	60.5%	72.0%
non Hawaiian	45.8%	80.1%	85.4%	84.2%	76.8%	65.1%	30.0%	69.9%

Note: Women who had pap tests within 3 years. **data suppressed
Source: Behavioral Risk Factor Surveillance System (BRFSS), 2016.

In 2016, no data was reported for Native Hawaiian women ages 18–24. Native Hawaiian women ages 65+ years had more pap tests compared to non-Hawaiian women.

Ovarian cancer causes more deaths than any other cancer of the female reproductive system. Unfortunately, a pap smear does not detect ovarian cancer and there are currently no good tests for early detection. Research indicates clusters of women who can discuss their concerns with their health provider: those at higher risk include women who never had children, had unexplained infertility, or had a first child after age 30 (NIH, MedlinePlus, 2007). At risk are women who used estrogen alone as hormone replacement therapy or have a family history of hereditary non-polyposis colon cancer or breast cancer. Ovarian cancer tends to occur in women after age 50 (Ibid).

Five main types of gynecologic cancer affect women's reproductive organs: cervical, ovarian, uterine, vaginal, and vulvar. Transmitted through sexual activity, human papillomavirus (HPV) may cause women to develop cervical cancer. From 2000–2005, Native Hawaiian (9.6) incidence rates of cervical cancer exceeded the state rate for all races (7.8). Mortality rates—though small compared to the leading cancer deaths—among Native Hawaiians were 40 times higher than Whites (4.5 vs. 1.8). Incidence rates among Native Hawaiians were almost 40 times higher than Chinese (9.6 vs. 3.7) (Cancer Research Center of Hawai'i, 2010). These disparities in cervical cancer should be monitored in order to continue to educate men and women on HPV and safe sex practices.

The health and wellness of aging women is reflective of their development and encounters across their lifespan. Women who are 60 years and older make up a large

portion of the global population; it is estimated that by 2050, the number of aging women across the world will reach over 1 billion (World Health Organization, 2007).

As this particular population continues to increase, it is important that policies and programs shift their perspectives to include a gender lens. The leading causes of death among the global aging women's population is ischemic heart disease, stroke, and chronic obstructive pulmonary disease, which account for 45% of deaths among elder females (World Health Organization, 2009).

During this stage of life there are many factors that impact the health and wellbeing of aging women, including social relationships, lifestyle habits, and access to quality long-term care options. One difficulty of working with the aging population is the diversity that occurs throughout the group. Though all women over the age 60 are considered “aging,” there are vast differences in experience—the life a 60-year-old woman is much different than the life of a 75-year-old woman. This is also amplified when we compare quality of life across nations. In order to address the needs of this often-vulnerable population, we must strive to include aging women in all policies and programs. Pain and chronic conditions should be monitored as mākuā age to kūpuna.

LONG-TERM CARE

For women that live in poverty or impoverished neighborhoods or nations, their living conditions have a direct impact on their access to shelter, food, and healthcare. It is common that older women live in multi-generational homes—they are often caregivers, or are receiving care from their children. In many cases, these women

Figure 2.14: Trends In Cervical Cancer Incidence and Mortality Cases and Rates by Race-Ethnicity in Hawai'i (2000–2005)

Race/Ethnicity	Incidence		Mortality	
	Cases/ Year	Incidence Rate	Deaths/ Year	Mortality Rate
Native Hawaiian	10	9.6	5	4.5
White	12	7.0	3	1.8
Chinese	2	3.7	1	1.9
Filipino	10	10.4	2	2.1
Japanese	8	5.1	3	1.6
All Races	51	7.8	16	2.4

Note: Rates are per 100,000 population and are age-adjusted to the 2000 U.S. standard population.

Source: Hawai'i State. University of Hawai'i. Cancer Research Center of Hawai'i. Hawai'i Cancer Facts & Figures 2010.

are living in overcrowded conditions, but are unable to afford their own housing due to high costs and low income. On the other hand, aging women that live in developed and industrialized countries are more likely to live on their own, which can lead to a sense of isolation, and ultimately feelings of depression (World Health Organization, 2007).

As the population of women continues to grow and the number of potential care providers decreases, it is vital to develop alternative options of elderly care. Many aging women are unable to afford quality long-term care, or even basic necessities, which only exacerbates the financial burden they so often experience (World Health Organization, 2009). In many cases, elder care is often provided by family members or neighbors, as opposed to formal options. This burden is frequently shared by family members caring for their aging loved ones and impacts their social, economic, and health wellbeing. Unfortunately, the stress that begins to develop when providing long-term or elderly care can, and often does, escalate to elder abuse. Studies indicate that elder abuse is a common problem globally. One such research initiative in the European Union found overall rates of abuse among elderly women to be as high as 28.1% (United Nations, 2013). In the U.S. alone, it is estimated that for

every report made to Adult Protective Services, about five cases will go unreported (OWL, 2009). It is imperative that continued advocacy and protection is offered to this highly vulnerable population.

Interventions & Recommendations

Data has shown that women often have longer life expectancies than men, but comparisons among women and based on their educational attainment show definite disparities. Health behaviors are influenced by education, socioeconomic status, occupation, and environment. A study titled “Socioeconomic Status and Health: How Education, Income and Occupation Contribute to Risk Factors for Cardiovascular Disease” looked at different factors that influence health outcomes (Winkleby, Jatulis, Frank & Fortmann, 1992). It has been demonstrated that continued education from an early age can have positive impacts on the individual later in life. Life expectancy of aging women tends to have been positively correlated with

increased years in education. Older women that live in poverty or impoverished neighborhoods/environments are less likely to be physically active, participate in the workforce at lower rates, have lower life expectancies, and higher rates of mental illness. Poverty at this stage in life can only be addressed through prevention. To ensure our aging women's population has access to equitable income, economic support, etc. there needs to be "social safety nets" provided throughout the life course (World Health Organization, 2007). The socioeconomic status of women at this stage is also important, as the burden of health care costs only grows as women continue to age.

Obtaining a high school diploma alone results in a stable life expectancy, while 16 or more years of education will often increase life expectancy for women (Plewes, 2016). Additionally, access to education in earlier years impacts the socioeconomic status of aging women. Education and lower income had an influence among women, not only for increased smoking but also associated with HDL cholesterol. Education has been shown to not only improve the health outcomes of women individually, but also promote healthy lifestyles of their children (1992). Early interventions for proper nutrition, physical activity, and education of the impacts of substance use at the adolescent stage will, in turn, likely decrease chronic disease rates in adult women.

REGULAR PHYSICAL ACTIVITY

In addition, international consensus agrees that participation in physical activities can offer a great deal of benefits to individuals, communities, and nations. The physical benefits of regular physical activity are well-established: it is associated with a longer and better quality of life, reduced risks of a variety of diseases, and many psychological and emotional benefits (Centers for Disease Control and Prevention, 2015). Physical activity may influence the physical health of young girls in two additional ways. First, it can affect the causes of disease during childhood and youth. Evidence suggests a positive relationship between physical activities and a host of factors affecting girls' physical health, including diabetes, blood pressure, and the ability to use fat for energy. Second, physical activity can reduce the risk of chronic diseases later in life. However, differences in gender-based attitudes towards and opportunities for

sports and physical activity can have a significant influence on children's participation. This may, in turn, affect later involvement in physically active lifestyles, and the social and health benefits that may result.

SOCIAL SUPPORT

Research has shown that the maintenance of supportive relationships can result in health promotion and healthy behaviors. Stronger communities provide individuals with more control over the decisions in their lives, offer local solutions to local challenges, and promote a healthy lifestyle. By looking at connected factors, communities, policy makers, and health practitioners can make better decisions on how to improve Hawai'i's health conditions. Factors like education, economics, income, and housing contribute to health disparities among Native Hawaiians (Ostrowski & Fox, 2016).

Quality social relationships are integral in maintaining healthy lifestyles throughout the aging process, and for aging women living independently, these social relationships and supports can be the determining factor for the mental and physical wellness. Focus groups held with aging women in the U.S. have demonstrated the importance of social supports in achieving and maintaining balanced wellness, and those aging women that engage with others often have lower rates of heart disease and depression. These focus groups also provided insight on the importance of maintaining an active lifestyle in one's older years, and many of the women felt physical activity not only improved their physical health, but their mental health as well (National Women's Health Resource Center, 2008). Likewise, social supports and positive networking often encourage women to seek out care and become aware of issues impacting their health (Hurdle, 2001).

NUTRITION

Not only are social supports and physical activity important for maintaining strong physical and mental health, but nutrition as well. One issue that arises is the ability of women to access healthy food choices at affordable prices.

AGE-SPECIFIC HEALTH POLICIES

KAIKAMAHINE

- » Increase communities with parks, walking areas, good schools, affordable housing, and readily available fresh fruits and vegetables that allow individuals to make healthy personal choices, while saving money and resources that would otherwise be spent on health issues. These should be specifically created in underserved communities with high rates of poverty.
- » Promote food security and access to healthy food choices in Hawai'i.
- » Address early education equity, including universal access to Pre-Kindergarten education.

‘ŌPIO

- » Create a health workforce that is specifically trained in adolescent health issues.
- » Address social barriers often associated with sexual and reproductive health, especially within schools.
- » Expand health education and promotion activities that not only include adolescent girls, but their families as well. These should raise awareness toward the importance of physical activity and proper nutrition in relation to wāhine well-being. This will help shift lifestyle choices individually, as well as in familial environments.
- » Increase cancer screening for young adults.
- » Advertise, educate, and initiate smoking cessation programs for young adults and their use of electronic cigarettes.

MĀKUA

- » The Women's Preventive Services Initiative (WPSI) recommends that women initiate mammography screening no earlier than age 40 and no later than age 50.
- » Additionally, clinical breast exams or breast self-exams (BSE) may detect lumps and physical changes in the breast for early cancer detection. The Healthy People 2020 target for breast cancer screening is 81.1%. Mammograms, clinical breast exams, and BSE can aid in cancer detection at earlier stages.
- » WPSI recommends cervical cancer screening for women between the average-risk ages 21–65 years using a pap smear test. Women between the ages of 21 and 29 are recommended to get a pap smear every three years. Between ages 30 and 65, a Pap test and a HPV test (co-testing) is recommended every five years.
- » Create initiatives that address physical and mental health in combination for wāhine.
- » Systemic work must be done to address asthma and obesity among wāhine.

KŪPUNA

- » Screening mammography should occur at least biennially and as frequently as annually. Screening should continue through at least age 74 and age alone should not be the basis to discontinue screening.
- » Chronic conditions and pain should be assessed among Native Hawaiian elders in an effort to preserve their quality of life.
- » Aging women's daily micronutrient levels change, but the daily levels for this population are not necessarily understood. It is important that continued research be done in elderly nutrition to better educate aging women on their nutritional needs (Ibid).

Leina'ala Bright: Primary Care that includes Cultural Health

In 2016, Waimānalo Health Center brought in cultural health specialist Leina'ala Bright, MA, to help integrate traditional Hawaiian healing techniques into the center's medical practices.

After practicing lomilomi for nearly 30 years, and lā'au lapa'au for a decade, Bright has become an essential addition at the community health center, which serves a significant Hawaiian population throughout the Ko'olau region. "We're working on integrating our programs to expand upon our cultural foundation," Bright says. "I believe it is empowering to have traditional health care as part of our regular services, helping kanaka 'ōiwi to remember and reclaim our ways of healing."

Bright is part of the primary care team at the health center, where she helps to care for patients just as a behavioral health specialist or nutritionist would. While the primary care physician works with a patient, she might lomi the patient or offer alternative treatments that match their needs. "It is exciting to be a part of a health care team... I believe it is important to have a Native Hawaiian health care practitioner participate with the doctor in offering support and complementary care," she points out.

Bright has long been a community healer, but being a core team member at the health center has expanded her reach to help those in need. Clients can learn more about traditional remedies and treatments through Bright's popular community classes, which tend to attract mothers, children, and kūpuna during the day, and families in the evenings. "There are so many stressors in wāhine's lives now; we are responsible for our families, and sometimes even our kāne. There's a heavy drug influence in our community, and obesity with its inherent risks is a problem as well," Bright describes. "Women are the piko of the family. And when we start to make slight changes, it just blossoms through the family and the healing grows from there."

Bright learned Pa Ola lomilomi from Kahuna Lomilomi Alva James Andrews, and lā'au lapa'au from Kahuna Levon Ohai; she teaches Ohai's techniques, taking a holistic approach to well-being that incorporates Seven Laws of Health: pule, pondering, meditation, diet, sleep, exercise, and cleansing. Patients may learn how ko'oko'olau tea helps balance their blood sugar, or how pohe kula helps with dementia, hypertension, and respiratory problems.

While Bright offers patients teas and medicinal salves that she makes using traditional techniques, she also instructs and encourages mahi lā'au lapa'au at home. Bright teaches patients how to propagate plants at home and use them to prepare medicine from the 'āina. "When they do," she explains. "They'll have their own healing garden and hopefully become a little more self-sustaining and self-empowered."



Motherhood

CHAPTER 3

Ku‘u ēwe, ku‘u piko, ku‘u iwi, ku‘u koko.

My umbilical cord, my navel, my bones, my blood.

(‘Ōlelo No‘eau, #1932)



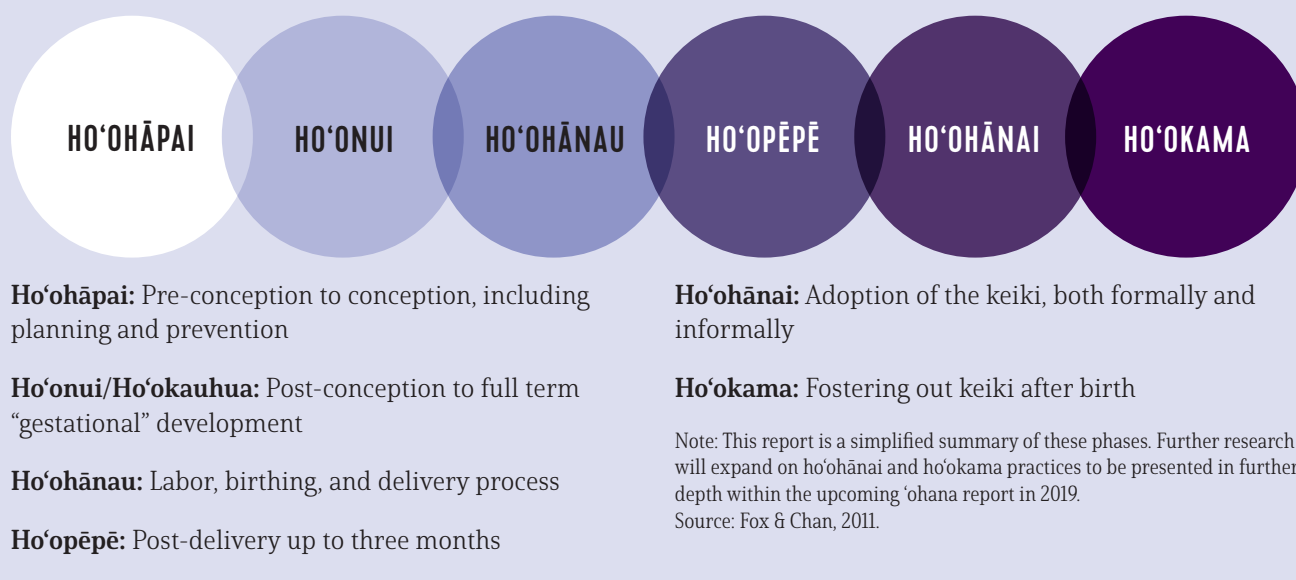
Issue Data for Intervention: Motherhood

- » Among female middle school students, 42.4% of Native Hawaiian students reported using a condom the last time they had sexual intercourse, 18.1% less than non-Hawaiian female students in middle school.
- » A 10-year aggregate shows 45% of the extremely preterm births in Hawai‘i are born to Native Hawaiian mothers.
- » But surprisingly, 33% of the extremely preterm births in Hawai‘i are born to Native Hawaiian mothers in high income communities, which is more than double any other race in the State.
- » Native Hawaiians have the highest rates of infant mortality in Hawai‘i—2.3 times greater than Caucasians.
- » Native Hawaiian mākuahine (mothers) of all ages surveyed had higher rates of postpartum depression than the state and non-Hawaiians from 2012–2014.
- » The largest breast feeding gap is among Native Hawaiian mothers ages 35+, who breastfed 4.3% less than non-Hawaiian women in the same group.

In ancient Hawaiian society, almost every aspect and stage of life in ancient Hawaiian society was governed by kapu (sacred regulations) that were intended to maintain mana and, in turn, positively affect health. This strong association of mana with health necessitated strict observance of kapu that were considered essential for female well-being as a kaikamahine (girl) developed into adulthood.

In addition to the general kapu observed by everyone, there was a special set of kapu for women. Deep sea fishing, including handling fishnets and certain tools, was prohibited, as was the attendance at most heiau and the wearing of feather items, except feather lei. A number of foods were forbidden, and death could be the punishment. The kapu on certain foods was attributed by some to the fact that those foods caused a form of ‘ea (general term for infections and infectious diseases) which resulted in a buildup of mucus in the female body, especially in the reproductive and sexual organs. This in turn caused a loss of sexual pleasure, decreased fertility, and increased miscarriage. (Gutmanis, 1992, p. 35)

Figure 3.1: Native Hawaiian Motherhood Phases



The above figure on motherhood provides an overview to basic women's health, maternal, and child practices, and the force of wāhine to generate life for the lāhui.

Emerging Womanhood and Reproductive Health

PE'A PROTOCOLS & MENSTRUATION

Certain practices surrounding female reproductive systems and birthing existed to protect wāhine and ensure strength and health for both the mother and child. The flowing of blood was considered haumia, or ceremonially unclean (Andrews, 1865) and thus during menstruation wāhine did not partake in regular daily activities. Haumia is the ancestress of Paikea and mother of war god Kekauakahi, and is the goddess associated with defilement and female ma'i (genitalia) (Pukui & Elbert, 1964).

During menstruation (referred to as kahe, hanawai, ma'i wahine, pe'a, or wai o ka wahine in Handy, et al. 1934; Pukui & Elbert, 1986), wāhine stayed in the hale pe'a, a house specifically reserved for women during that time of haumia. Wāhine used their old pā'ū (skirt) and with pulu (soft wool) from the hapu'u fern as sanitary napkins; their used sanitary napkins were not burned in a fire but buried outside the hale pe'a (Handy & Pukui, 1972). For

spiritual protection during this time, they tied kī (green ti leaf) to them, and kī are still believed to afford protection from spirits and to purify menstruating woman (Handy & Pukui, 1972), kī being a kinolau (physical manifestation) for wāhine dieties. Wāhine were restricted by the kahapouli (kapu for menstruating women) from doing other activities during this time and instead focused on self-care. Men were not allowed in or near the hale pe'a, and food was brought to the entrance by other female relatives. Higher-ranking wāhine who acted as wet-nurses for ali'i children were not allowed to nurse the child while menstruating, and were required to nurse the child naked so as not to hide if she were (Pukui, 1942), in order to guard the mana inherited by high-ranking births.

After menstruation, wāhine would perform a kapu kai, a ceremonial purification bath in the ocean (Pukui & Elbert, 1986). After the kapu kai was complete and the protocols were successful, the female would be allowed to reenter the hale noa and resume their normal activities.

There is a scarcity of published scholarship regarding menstruation and practices of women's development, especially regarding the kokopuna (first menstruation) or the ho'oki'o (last menstruation initiating menopause). This includes the transition of a girl to a woman and her role shifting within the kauhale and her 'ohana. Many

indigenous cultures around the world use the onset of menstruation to discuss the biology of reproduction, but also proclaim this time to reproductive vitality, retelling the histories and personal stories of her 'ohana, placing her securely in her future with strength and positivity. This time period can once again utilize celebratory ceremonies and protocol to reinforce puberty among Native Hawaiian girls. A transition which can celebrate reproductive justice among Native Hawaiian females. However, we also recognize that details may be considered huna (hidden) and academic publications may not be the leading platform for sharing these traditions.

ADOLESCENCE AND SEXUAL HEALTH

Adolescence is the transitional stage from childhood into adulthood. Many young girls begin their reproductive cycles and become more familiar with their reproductive roles. Today, although global rates of teen pregnancy and sexually transmitted diseases (STDs) have steadily decreased due to improved access to reproductive health services, many young girls continue to face barriers in reproductive health. In the US, adolescent girls' access to reproductive care is based on insurance coverage, ability to pay, and the availability of family planning services (Hock-Long et. al, 2003).

An additional barrier to reproductive health care for any adolescent girl is the stigma often associated with sexual

and reproductive health. Data regarding unsafe sexual behaviors often go under-reported due to this stigma, which often hinders young girls from asking the right questions about their sexual and reproductive health (Glasier et. al, 2006). Breaking down barriers and normalizing discussions surrounding these issues may vastly improve the reproductive health outcomes for adolescent girls. This may spark discussion of safe-sex practices and behaviors, thus promoting condom and contraceptive use among adolescents.

High-risk sexual behaviors of adolescents can result in STDs. The five sexual-behavior indicators track Hawai'i public middle school and high school Native Hawaiian and non-Hawaiian female students are reported from the Youth Risk Behavior Survey (YRBS) in Figure 3.2.

This survey indicates that 60% of Native Hawaiian high school female students had spoke with a doctor or nurse about ways to prevent STDs, this is more than double the amount of Native Hawaiian middle school female students who were ever talked to (30%). More Native Hawaiian students engaged in talks with a doctor regarding STD prevention than non-Hawaiian students (30% vs 16%), and there were twice as many Native Hawaiian high school students than middle school students (60% vs 30%). More Native Hawaiian students engaged in family talks regarding sex compared to non-Hawaiian students. 56% of Native Hawaiian high school students and 46% of middle school students had these talks.

Figure 3.2: Sexual-Behavior Indicators Among Female Students (2017)

YRBS Indicators	Middle School (MS)		High School (HS)	
	Native Hawaiian	non-Hawaiian	Native Hawaiian	non-Hawaiian
Condom use	42.4%	60.5%	42.8%	46.9%
Family talks regarding sex	45.9%	43.9%	56.4%	54.9%
Dr talks regarding STD	29.7%	16.4%	60.3%	43.1%
HIV/AIDS education at school	43.9%	39.3%	69.6%	72.4%
Family talks regarding HIV/AIDS	30.7%	37.1%	52.2%	41.2%

Source: Youth Risk Behavior Survey (YRBS)

Despite these strategies that can exert a preventive influence, among female middle school students, 42.4% of Native Hawaiian students reported using a condom the last time they had sexual intercourse, 18.1% less than non-Hawaiian female students in middle school. Non-Hawaiian students had higher percentages than Native Hawaiian students for condom use: 5 percentage points for middle school and 4 percentage points for high school.

Ho'ohāpai: Prevention and Prenatal Planning

Although babies were viewed as a sacred and vital part of Native Hawaiian spiritual beliefs surrounding generative mana, wāhine of ancient Hawai'i valued prenatal planning and practiced methods of birth control to circumvent unintended pregnancies. Historian June Gutmanis (1992) notes, "Females were acquainted at an early age with the knowledge that they could to some extent control the reproductive processes" (p. 31). Consequently, they were able to exercise some control over decisions of when to have a child, how many children to have and how far apart they should be.

Prenatal planning was related to the concept that bringing a new life and a new spirit into the physical world, and entailed complex responsibilities (Bushnell, 1993). While traditional Native Hawaiian birth control methods are discussed because historical literature explores Native Hawaiian understandings of female and infant health, this report attempts to historically document a seldom understood set of practices in our traditional culture. As such, prenatal planning was regarded as an important way to honor and ensure proper passage of mana.

OPTIONS & CONTROL PRACTICES

In addition to the kūkapu, the kapu that made a female chaste and unapproachable (Pukui & Elbert, 2003), there was a law of chastity described as follows: "Pa'a i ke kânāwai kamaka'aha" (Pukui, 1983). Translated as, "Held by the law of the sennit girdle. Taken an oath to remain chaste. Lu'ukia, wife of the high chief Olopana, designed

and made a girdle of sennit to prevent her lover and brother-in-law from approaching her" (p. 2556). The 'aha (sennit) is a cord braided of coconut husk, human hair, and animal intestines (Pukui & Elbert, 2003) to indicate that a wāhine was under kūkapu and that kāne must respect the kânāwai kamaka'aha set by her parents to ensure she was unviolated (Andrews 1865; Parker 1922).

According to Mary Kawena Pukui, birth control was one method used by the woman to address unwanted pregnancy. Birth control was practiced because too many children too close together were considered undesirable. The woman who had another baby ten to eleven months after giving birth was scorned. "People talked about her. They would say, 'Why, the walewale (lochia) for this child hasn't even stopped, and she's having another child on the end of it...'. Any wāhine (woman) who had too many babies in too little time was fair target for every waha ko'u (clucking mouth) in the neighborhood." (Gutmanis, 1992, p. 32) The practice of spacing births is captured in the 'ōlelo no'ēau: "Ka'ika'i i ka lima, hi'i i ke alo. *Lead with one hand, carry with one arm.* Said of a mother with children born too close together" (Pukui, 1983, #1391).

To avoid unwanted pregnancies, it appears ancient Native Hawaiians used spermicide, abortion, and short-term or permanent closing of the womb via lā'au and surgical procedures.

Among the ali'i, preconception was critical to the mana of the ruling class. Rank and chiefly lines were considered of paramount importance to bring kāne and wāhine together with ritualized ceremony to enhance the period of preconception. For the ali'i, the choosing of a partner was more selective to ensure the hiapo (first born) would be of high rank (Malo, 1903). If a pregnancy was undesired, wāhine could have an abortion, known traditionally in practice as 'ōmilomilo. Pukui states that 'ōmilomilo was usually performed for a high-ranking wāhine who had become pregnant from a lower-ranking ali'i (1942), such as Malaekahana, in this example she is the wife of a chief of O'ahu. Within the Haleole text of *Ka Mo'olelo o Lā'ieikawai*, because the conception of an infant girl between Malaekahana and Kahauokapaka was undesirable until a son was born, "ina i ike oe he kaikamahine, e omilomilo ae au" (to cause the death of an unborn infant) (Haleole, 1863, p. 11). Here, 'ōmilomilo means to destroy or cause the death of an unborn infant. The Andrews dictionary (1865) categorizes "omilo" as the name of a medicine used in procuring abortion; he lā'au lapa'au; applied

to the operation or to the medicine used in procuring abortion. David Malo states that abortion was not considered wrong or evil (Malo, 1903).

Laaupa was a medicine that was used to induce abortion or perhaps prevent pregnancy (Andrews, 1865), and would be similar to what's known as "emergency contraception" in contemporary medicine. Unwanted pregnancies were also controlled with elixirs made by the kāhuna lā'au lapa'au; "Several medicinal agents in the native pharmacopoeia, compounded in apu and drunk, or applied externally or internally in late pregnancy, are said to act as an abortive" (Handy et al., 1934, p. 8). Hau (*Hibiscus tiliaceu*), noni (*Morinda citrifolia*), 'awa (*Piper methysticum*), 'ōhi'a 'ai (*Syzygium malaccense*), and young kī (*Taetisa frucicosa* or *Cordyline terminalis*) leaves were among these lā'au (Gutmanis, 1992; Handy et al., 1934). Andrews (1865) notates the followings subject in 'ōlelo Hawai'i: "Inu nui na wahine i ka laaupa i hapai ole lakou. He laau hanau keiki ole"; Oo was a process to abort a child in the womb (Andrews, 1865), comparable to surgical abortions completed by OB/GYN's in conventional medicine today. Wāhine were not ostracized for this practice.

FERTILITY

Considered to be intermediaries for successful birth outcomes, the kāhuna of Hawai'i developed specialized professions that included a select group of healers. These individuals addressed health issues in the obstetric, gynecological, and pediatric fields of medicine. Kāhuna ho'ohāpai keiki and kāhuna ho'ohānau keiki of Kū, Lono, Kāne, and Hina orders had many ways to induce pregnancy among women who had ceased bearing children (opu pa), or who had never given birth (hānau keiki 'ole), including plants and prayer.

If they had a hard time conceiving naturally, a couple could address it several ways. For example, wāhine experiencing infertility gave offerings to fertility stones. One such known stone was Ka Ule Nānāhoa on the island of Moloka'i (Pukui, 1942). They also gave offerings to the kāhuna of Kū, Hina, Lono, or Kāne lines to appeal to the divine power of those akua. A child conceived from those offerings was called a "keiki o ke akua," or "child of god" (Kamakau, 1870, p. 1). If pregnancy did not result from these, the wāhine could have sex with another man

wāhine experiencing infertility gave offerings to fertility stones

to conceive a child (Handy & Pukui, 1972). The child was called "hua 'e" and was not considered any less welcome in a family than their biological kin.

In the event of a he'ewale or a miscarriage, the closest male relative usually placed the fetus, called "pu'u-koko," to an area related to the family 'aumakua (family god), who then cared for it (Pukui, 1942). For example if the 'aumakua was a manō (shark), the fetus was taken to the ocean. Pukui states that the unborn fetus was thought to acquire mana when it was properly cared for in this way (Pukui, 1942). In Hawaiian custom, an infant resulting from a difficult birth often become famed individuals. The most well-known is Hāloa, the first born of Papa and Wākea who was stillborn, and from whose grave grew the first kalo plant. In another example, shortly after Keōpūolani gave birth to Kauikeaouli, it was thought that the child had died; however, Kaikio'ewa came with his two kaula—Kamalo'ihi and Kapihe—who chanted over the child and restored his life (Kamakau, 2001). Kauikeaouli went on to become the longest-reigning mō'i of the Kamehameha line.

CONTEMPORARY PREGNANCY

The underlying issues that impact views of contraception and pregnancy vary based on cultural and social norms, views, knowledge, and attitudes of communities (Dehlendorf et al., 2010). In Western medicine, unintended pregnancies are defined as mistimed, unplanned, or unwanted pregnancies (Yazdkhasti et al., 2015). Data has shown that 41% of pregnancies worldwide were unintended in 2012, while in the US 51% of pregnancies were unintended (Sedgh, Singh, & Hussain, 2014; Finer & Zolna, 2014). Figure 3.3 illustrates unintended pregnancies among teenage females in Hawai'i based on a few indicators.

Figure 3.3: Teen Pregnancy (2007–2011)

	Intended	Mis-timed	Unwanted
Native Hawaiian	20.2	67.4	12.4
non-Hawaiian	22.1	65.0	12.9
State	21.1	66.2	12.7

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS)

In Hawai'i, nearly 4/5 of all pregnancies for women under 20 years of age were considered unintended by the female. Data here indicate fairly consistent rates of unintended pregnancy, mistimed pregnancy and unwanted pregnancy across five years.

The percent of births to mothers under the age of 18 by community is ranked as follows for the years 2008–2013 (HDOH, 2016, p. 80):

1. Wai'anae—4.6% or 256/5580 live births
2. Ka'ū—4.8% or 25/524 live births
3. Moloka'i—4.0% or 25/628 live births
4. Waimea (Kaua'i)—3.5% or 28/803 live births
5. Hāna—3.4% or 6/179 live births

Native Hawaiians experience the highest reported rate of unintended pregnancy of any ethnic group in Hawai'i, but that does not mean these pregnancies are unwanted. “Moreover, subgroup differences (by income and educational status, for example) are increasing. Hawai'i, one of the most ethnically diverse states in the nation, had the second-highest unintended pregnancy rate in the United States in 2010 (61 per 1,000 women aged 15–44)” (Soon, Elia, Beckwith, Kaneshiro, B., & Dye, 2015, p. 2).

Disparities of intended and unintended pregnancies exist due to the financial and social inequities minority and low-income women experience. Women in the US who earn less than 100% of the Federal Poverty Line are more likely to have an unintended pregnancy, with 62% of women in this population having experienced one (Dehlendorf et. al, 2010). These women are also less likely to engage in family planning behaviors, such as

contraceptive use. Research has demonstrated that unintended pregnancies carried to term are less likely to access adequate or timely prenatal care, which can lead to poor birth outcomes such as low birth weight, infant mortality, and maternal morbidity (Ibid).

Additionally, unintended pregnancies can negatively impact child development, and are often exacerbated when adolescents unintentionally get pregnant. Review of data indicate teen pregnancies can create economic burdens on the health care, child welfare, and criminal justice systems. This vulnerable population must often make difficult decisions regarding their education and career opportunities, resulting in higher rates of school drop-outs and poverty (Dehlendorf et. al, 2010). Subsequently, their children face poor health outcomes across their lifespan (Family Health Services Division, 2014). Children of unintended pregnancies often have developmental delays, experience behavioral problems, and may remain in a cycle of poverty and low educational attainment (Dehlendorf et. al, 2010). Multi-variable analyses like these can be conducted in Hawai'i with more updated rates and access to datasets. Health economists, for example, can explore levels of influence for local disparities and the burden of disparities.

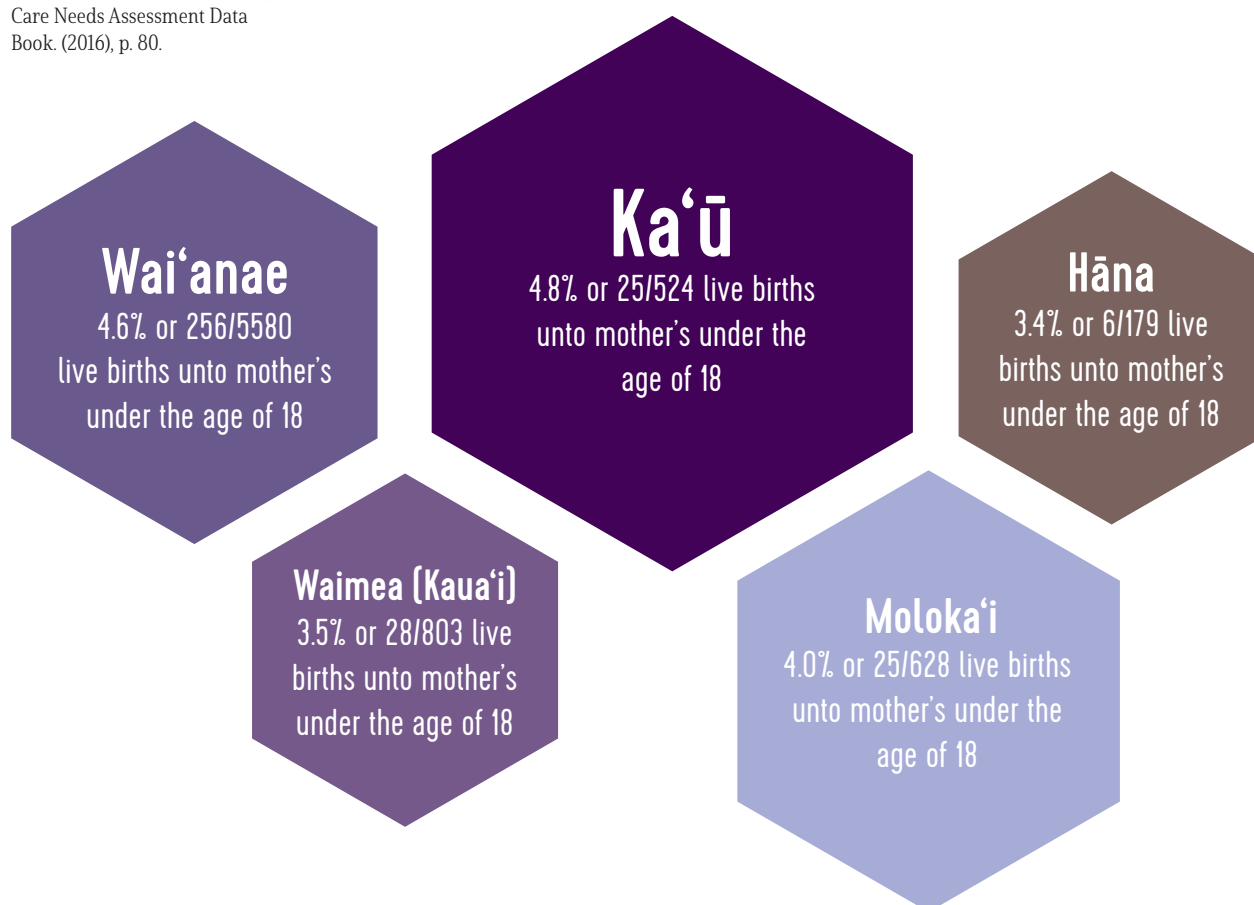
Ho'onui: Pregnancy

While hāpai, wāhine observed a special diet to prevent harm to the growing fetus and to encourage strong development of its body, mind, and spirit, the connections of piko, and the health of the 'iwe (placenta). Hawaiian use of nutrition as medicinal not only prevented ma'i (illness) but enlivened ola (well-being). Because Native Hawaiians equated prenatal health with long-term outcomes, including personality traits and other characteristics, the role of relational influences on health are especially valuable concepts to explore in this report. For example, Native Hawaiians believed that “should a woman become ill during pregnancy, her child will have a mean nature” (Green & Beckwith, 1926, p. 231).

Certain seafoods and foods with strong flavor such as nīoi (chili pepper) or onions were avoided. Greens, such as lū'au (taro leaves), pōpolo (black nightshade),

Figure 3.4: Hawai'i Births to Mothers Under the Age of 18 by Community (2008–2013)

Source: State of Hawai'i Primary
Care Needs Assessment Data
Book. (2016), p. 80.



and pālula (sweet potato leaves) were encouraged to strengthen the growing fetus (Handy & Pukui, 1972). Cravings of the pregnant mother were believed to be caused by the nature of the child and the characteristics they would possess when they grew into adulthood (Handy & Pukui, 1985). For example, kōlea are the Pacific golden plovers that migrate throughout the year and are 'aumākua representing prosperity in some communities (Pukui & Elbert, 2003). As described in the 'ōlelo no'ēau: "I ho'okauhua i ke kōlea, no Kahiki ana ke keiki.—*When there is a desire for plovers, the child-to-be will travel to kahiki.* Said of a pregnant woman. If she craves plovers, her child will someday travel to foreign lands" (Pukui, p.127). In a well-known mo'olelo, Kamehameha's mother craved the eye of the niuhi (tiger) shark, which foretold how he would one day become a fierce warrior, as the niuhi is known within the sea (Pukui, Haertig & Lee,

1972; Desha & Frazier, 2002). To protect her child, an expectant mother also refrained from wearing a lei around her neck, which might cause the umbilical cord to wrap around the child's neck (Pukui, Haertig, & Lee, 1979), and this tradition continues, where wāhine hāpai refrain from wearing a tied lei, necklace, or work lanyard.

In the Hawaiian religion, gods associated with creation were worshiped as part of the care surrounding pregnancy. 'Aumākua (ancestral gods) were also recognized within the order of supreme beings who could positively or negatively affect the health of the mother and child. Thus, "The parents or grandparents would pray to the 'aumakua for health and strength for the mother and child. And the woman was always watched carefully, so the baby would come safely" (Pukui et al., 1972, p. 4).

Ho'ohānau: Birth

Although sacred, the birthing process wasn't shrouded in mystery in ka wā kahiko; Pukui (1942) stated that "as far back as I can remember, birth was frankly discussed before me" (p. 357). The birth initiated new precautions, protective protocols, and customs to ensure the health of the mother and child. When labor was impending, preparations started for the ho'ohānau stage to begin. A birthing place was chosen in relation to the caste structure of the ancient hierarchy, and in some cases, a special structure was created for birthing in order to ensure the mother's privacy—a practice likely linked to the kapu surrounding the by-products of birth (Handy, 1927). Often occurring in a temple, the births of ali'i were distinguished for the high level of mana transmitted from the akua to the infant (Handy, 1927). Ali'i wāhine of highest noble rank delivered their babies at birthing stone sites, such as those at Kūkaniloko on O'ahu (Gutmanis, 1992; Handy, 1927). Due to the sacredness of Kūkaniloko, chiefs born there were considered akua on the land (Kamakau, 1991). These sites would be chosen, with respect to the level of mana each held for a class or clan.

However, most traditional wāhine hāpai practices would customarily be performed in the home. Gutmanis (1992) notes: "For lesser chiefs, birth would take place either at the local medical heiau specializing in obstetrics or in a house especially constructed for the purpose. For the ma-ka'ainana (commoner) birth might be at a medical heiau but delivery at home by a kahuna or a midwife with some female relative helping was most common" (p. 36). Other accounts note that women went into the woods for ten days to give birth (Handy, 1927).

TRADITIONAL MEDICAL CARE

Although Hawaiian society had an overarching health-care system maintained by the kāhuna class, not all individuals sought these services. Prenatal care practices were often maintained within highly developed family systems or in the community. The father or a pale keiki (midwife) aided in the delivery of a baby, as did others in their 'ohana. Pale keiki were frequently called upon in place of a kāhuna ho'ohānau keiki (experts in matters related to birthing). It should be noted that a pale keiki was "more often a woman, though men could also

be 'midwives'" (Pukui et al. 1972, p. 3). The expertise of the pale keiki was the result of keen observance of the material world as well as attention to hō'ailona (signs) or hihi'o (visions). Coupled with an exhaustive scientific approach, the practices of the pale keiki accounted for the needs of both the mother and unborn child.

The kahuna ho'ohānau was the conceptual equivalent of our modern obstetrician. Medicinal remedies ranged from simplistic ones to compound procedures. He would be called to a mother having difficulty in labor or help her so she would have less pain, for example. A kahuna ho'ohānau could also adjust a child if it failed to make progress (Larsen, 1946; Pukui, 1943). Through external palpation such experts are said to be able to make precise prognosis of when labor would start, "adjust the fetus' position through gentle and skilful massage, and, after delivery, to assist the extrusion of the placenta" (Handy et al., p. 9).

In Hawaiian tradition, labor pains can be transferred from the mother to another person. Mary Kawena Pukui described her sister's labor pains being transferred to a lazy uncle who was sleeping in the other room (1942). While in labor, if the mother longed to see someone it was believed that the child would be like that person (Handy & Pukui, 1972).

HISTORICAL SHIFTS IN BIRTHING PRACTICE

Traditionally, "the Hawaiian position for giving birth is squatting, with the feet braced, while a relative—mother, female relative, or husband—sits behind supporting the upper body" (Handy, et al. 1934, p. 9). Sometimes the woman hooks her legs over the knees of her helper, who is seated, and braces her back against their chest. "The upper abdomen is lightly massaged and gentle downward pressure is applied with the hands, and in the small of the back with the helper's knees. The woman may cling with both arms around the neck of her helper" (Handy, et al. 1934, p. 9). Ali'i wāhine gave birth leaning against reclining stones. Surrounding her were 36 stones on which sat chiefessess—royal midwives (Ibid).

In 1820, the first company of American missionaries arrived, including missionary-affiliated physicians in Hawai'i, who would introduce medical practices and beliefs that reflected the teachings of the religious communities of New England. As a result, Native Hawaiian

Figure 3.5: Female Preconception Health Access (2011)

Mother's Age	<20	20–24	25–34	35+	Overall
Native Hawaiian	29.7	33.2	36.0	35.1	34.1
non-Hawaiian	40.7	34.0	42.2	41.0	40.3
State	34.7	33.6	40.6	40.0	38.4

Note: Ethnicity = DOH Race/Ethnicity. Question: Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk with you about how to prepare for a healthy pregnancy and baby? Numbers reflect “yes.”

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS)

Figure 3.6: Preterm Delivery by Mother's Age-Group (2012–2014)

	<20	20–24	25–34	35+	Overall
Native Hawaiian	9.3	8.5	8.7	10.3	8.9
non-Hawaiian	**	7.1	8.7	10.6	8.9
State	9.5	7.7	8.7	11.0	9.0

** Data suppressed. Note: The gestational age comes from the birth certificate. Delivery is considered preterm when the gestational age is 36 weeks or less.

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS)

Figure 3.7: Low Birth Weight Delivery by Mother's Age-Group (2010–2014)

	<20	20–24	25–34	35+
Native Hawaiian	10.2	5.9	6.4	9.0
non-Hawaiian	9.5	6.6	6.7	8.8
State	9.9	6.3	6.6	8.8

Note: low (<2500 grams) vs normal (2500+ grams)

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS)

conceptions of health and traditional healthcare practices were vastly altered. Many of these changes were focused on female health, as a wide range of social ills were attributed to women during this era.

Prenatal care and childbirth were among the areas of women's health altered by the missionary teachings.

Wāhine were instructed to lie on their backs in a bed to deliver their newborns. This was but one way in which the Christian doctors and missionary women subverted the medical philosophies and practices associated with traditional Hawaiian maternal care, inhibiting the inter-generational transmission of traditional healthcare.

PRETERM DELIVERY AND NICU ADMISSION

Despite modern medicine, many pregnancies do not reach full term (37 weeks of a 40-week pregnancy). Some factors putting women at a higher risk of preterm delivery include lifestyle choices (e.g., smoking, alcohol, drugs, and violence), being pregnant with multiples, having a history of preterm labor, experiencing a medical condition, and having specific abnormalities with uterine or cervical functions. Approximately 10% of births in the U.S. were preterm and about two-thirds of babies receiving care in the NICU are premature in 2015. It is the single largest cause of death among newborns and infants: 17% of infant mortalities in 2015 were caused by low birth weight and/or premature delivery. Those who survive have a higher risk of health issues, physical and developmental delays, behavioral difficulties, neurological disorders and autism later in life (Premature Labor, 2012; Preterm labor, n.d.; CDC, 2017; Long-term health effects of premature birth, n.d.).

8.9% of all babies born to Native Hawaiian mothers in the State are considered preterm (gestational age is 36 weeks or less), the same as babies born to non-Hawaiian mothers (2012–2014). Non-Hispanic White preterm births in Hawai'i were 7.56% in 2015, respectively (Martin, Hamilton, Osterman, 2017). The largest percentage gap of preterm deliveries when comparing Native Hawaiian and non-Hawaiian mothers is in the 20–24 years of age range at 1.4 percentage points (8.5% vs 7.1%). One in ten Native Hawaiian mothers age 35+ experience preterm delivery (10.3%) among the age ranges.

Despite these rates, according to the Hawai'i State Department of Health, Vital Statistics from 2012–2014, Native Hawaiian infant deaths due to birth defects were the lowest in the state (0.4 deaths/1,000 live births) compared to Caucasian (1.0 deaths/1,000 live births) with no significant difference among male or female infants. However, low birth weight is a different case.

Low birth weight is defined as weighing less than 5 pounds 8 ounces at birth (<2500 grams), and this affects nearly 8% of babies born in the US (Martin, Hamilton, Osterman, 2017). Locally, 9% of all babies born to Native Hawaiian mothers in the State weigh less than 5 pounds 8 ounces at birth compared to 8.8% of babies born to non-Hawaiian mothers. The highest percentage of babies of low birth weight are born to Native Hawaiian women

20 years of age and younger at 10.2%; this is compared to non-Hawaiian women in the same age range at 9.5%; both of which are higher than the national average. Non-Hispanic White low birthweight births in Hawai'i were 5.8% in 2015, respectively (Martin, Hamilton, Osterman, 2017).

Low birth weight is primarily caused by premature birth (born prior to 37th week of gestation) since the fetus' gains the majority of their weight during the final weeks of pregnancy. Other factors that may contribute to low birth weights include: genetic influences, maternal health and lifestyle, insufficient pregnancy weight gain, history of low birth weight babies, multiples pregnancy, and/or uterine, cervical or placental abnormalities; and social factors, such as race, and low levels of income and education (Low birthweight, n.d.; Boston Children's Hospital, n.d.; Top 12 Causes Of Low Birth Weight In Babies, 2014).

Babies admitted into the Neonatal Intensive Care Unit (NICU) are either premature (born before 37 weeks gestation), have low-birth weight, experienced a difficult delivery, and/or present with one or more medical conditions. In 2012, approximately 7% of newborns were admitted into the NICU with babies born to women over 40 years of age being admitted at the highest rate of 10% in the U.S. (Osterman, Martin, Mathews & Hamilton, 2011; Common Diagnoses in the NICU, n.d.).

7.4% of all babies born to Native Hawaiian mothers in the State are admitted into the NICU, compared to 8.8% of babies born to non-Hawaiian mothers. 10.2% of babies born to Native Hawaiian mothers 35 years of age and older received NICU care, compared to 9.5% of babies born to non-Hawaiian mothers.

The fewest pēpē admitted to the NICU are born to mākuahine aged 25–34 years (6.2%). 10.2% of babies born to Native Hawaiian mothers 35 years of age and older receive NICU care, compared to 9.5% of babies born to non-Hawaiian mothers. The highest percentage of Native Hawaiian babies receiving NICU care are born to age 20 and younger at 11.6%; this is significantly lower than babies born to non-Hawaiian women in the same age range at 16.5%.

Ho'opēpē: Postpartum Care

In traditional society, kapu were in place to protect the infant, as a child was considered to be at a heightened risk of spiritual harm during the time spent in utero through postpartum. Physical and spiritual cleansing processes allowed individuals who had been exposed to blood during childbirth to be reintegrated into the community and to preserve their mana. Also, the extensive set of kapu surrounding pregnancy and childbirth protected the mother, immediate family, and larger community.

Shortly after the birth of a pēpē, a ceremony to close the womb was performed. “Called e ho’opa ike pu’ao [sic], this ceremony combined prayers, offerings, and herbal medicines. The womb was closed for a limited time or permanently, according to the woman’s wishes” (Gutmanis, 1992, p. 32; Handy et al., 1934). At this same time, the ‘iewe (“after-birth and navel string that connected the newborn with the mother” [Andrews dictionary, p. 73]) was also specially tended. Hawaiians believe that the ‘iewe took care of a baby prenatally, much like an elder sibling would care for a younger sibling, and respecting that bond was part of the postpartum care. Following the successful delivery, the ‘iewe was washed and sometimes buried under a tree as one way to dedicate its afterbirth. The traits of the tree are thought to connect with a person throughout their life. For example, “Puna maka kōkala.—*Puna of the eyelashes that curve upward like the thorns of the pandanus leaves.* The placenta of a newborn was buried under a pandanus tree so the child’s eyelashes would grow long like the pandanus thorns,” (Pukui, 1983, p. 302) was a well-known trait of the ancestors from Puna district of Hawai‘i.

According to Kamakau in *Ka Po‘e Kahiko* (1991), the place where the piko and ‘iewe of ali‘i reside have equal significance as the birthplace, and detailed records were kept through chants about the placement of the placenta (‘a’a), the navel string (ēwe) and navel cord (piko), especially the kingdoms of O‘ahu and Maui. He notes that later, these same places became the locations where the ‘iwi of the ali‘i were placed for burial rites.

In 2005, the so-called “Iewe Bill” passed in the Hawai‘i State Legislature. This bill enabled release of the baby’s ‘iewe from hospitals to families after a birth, as long as

the mother tested negative for certain diseases, such as HIV and hepatitis. Preserving this traditional practice is an important link between today and those in ka wā mamua. Many Hawaiian families continue this tradition today, planting a tree of significance for the ‘iewe or hiding it in an auspicious place for their ‘aumakua, even following hospital births.

Following a birth, the makuahine (mother) followed a special diet that consisted of broth sometimes made of fish or chicken and herbs to fill the empty space left within the ‘ōpū (womb) and to help flush out excessive blood. Ko‘oko‘olau (*Bidens asymmetrica*) was heated and brewed as a postpartum tea, both to purify and cleanse, and to restore her appetite (Chun, 1994). After she bathed, the mother’s abdomen was bound with kapa (barkcloth) until the discharge stopped (Pukui, 1942). This was an important phase to close the woman during the stage of ho’opēpē, lest she become sick and develop a serious ma‘i.

This bill enabled release of the baby’s ‘iewe from hospitals to families after a birth. . . Preserving this traditional practice is an important link between today and those in ka wā mamua.

Following the birth of the hiapo (first born), the ‘aha‘aina mawaewae, a ceremonial meal to dedicate the child to the ‘aumakua, was held to free the child from bad influences, and to clear the path for all the other children to be born (Handy & Pukui, 1972). During this time, foods that represented Lono were prepared and consumed by the mother such as lū‘au (taro leaves), ipu o Lono (gourd variety sacred to Lono), and pua‘a (pig), which then sealed the child to Lono. This ritual was done by the family only, and was not the same as the ‘aha‘aina pālala, which was the celebratory feast for the newborn.

Figure 3.8: NICU Admission After Birth by Mother's Age (2010–2014)

	<20	20–24	25–34	35+	Overall
Native Hawaiian	11.6	7.1	6.2	10.2	7.4
non-Hawaiian	16.5	9.4	7.9	9.5	8.8
State	13.7	8.4	7.5	9.6	8.4

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS)

Ali'i post-birth practices had some distinctions from the birth of maka'āinana. Following the first birth of an ali'i wahine, the mother spent an anahulu (ten-day period) away from her kāne (man) while she healed. During this process called “ho'opapa,” she took certain lā'au (medicine) and had a special diet (Malo, 1903). Mele inoa (name chants) were sometimes composed for a newborn ali'i in honor of the child's genealogy; for example, a name chant for Ke'elikolani entitled “He Inoa Keanolani,” appeared in *Ko Hawaii Pae Aina* in 1883 and is over 130 lines long.

A royal son (keiki ali'i) was taken to the heiau to be consecrated, and there his navel cord (piko) was cut, and the drums sounded, announcing the baby's birth. Both the 'iewe and child were washed well in water and taken care of by the kahuna, then he was wrapped in kapa and presented to the gods. When the rituals of the kahuna were ended, the child was returned home (Handy & Pukui, 1972, p. 27). With both boys and girls, special care was taken to place this piko waena (umbilical cord and belly button stump) in a safe place, as it was believed that the fate of that piko could affect the child later in life. Hawaiian families placed piko in special places where the cords of their 'ohana were kept safely for many generations (Pukui, 1983). For example, the Lindsey 'ohana on Hawai'i Island have a sacred place at Mauna Kea where the piko of their 'ohana rest (personal communication, Hind, 2015).

On the body, the pūniu (fontanel, also known as manawa) symbolized the spiritual link of the newborn to his ancestors, and was considered a vital point of transmission for inherited mana. Lā'au (medicinal plants) were used on the pūniu: “After the mother's milk appeared, the fontanel was plastered with pounded papala which drew out

the hidden disease ('ea huna) with which every child was born” (Gutmanis, 1992, p. 40). The spiritual use of lā'au was meant to keep the manawa (fontanel) open, which promoted mana transmission from the akua to the child, fortifying development. This connection was also solidified through healthy eating.

Maternal Mental Health

At least 1 in 10 women in Hawai'i experience postpartum depression, where having postpartum depression results in a 50–62% increased risk of developing future depressions. Postpartum depression can fall into categories based on the severity of symptoms, ranging from lack of concentration and sadness, to episodes of delusions and hallucinations. “Baby blues,” the short-term milder type of depression, affects 30%–80% of all new mothers and develops within the first week postpartum. The most severe type of depression is postpartum psychosis and occurs in only 1–2 in 1,000 women. However, these estimates do not include women who experienced stillbirth or miscarriages, and only account for women who were diagnosed and received treatment.

The impacts of postpartum depression are not only felt by the mother, but the child as well. Research indicates that children of women who suffer from postpartum depression are more likely to receive inadequate prenatal care, poor nutrition, birth outcomes, and long-term developmental and cognitive function issues. For infants, a mother's active daily participation and attention is vital in ensuring healthy developmental outcomes. Postpartum

Figure 3.9: Effects of Postpartum Depression on Infant and Child Development

Developmental Stage	Impacts of Postpartum Depression
Infancy	The infant will respond to these behaviors by developing passive and withdrawn behaviors that follow them through development. Infants of mother who have experienced postpartum depression have delayed cognitive development, as mothers are less inclined to stimulate responses from their infant.
Toddler	The lack of attentiveness and responsiveness from the mother results in the child not being able to develop proper behavioral functions, to handle negative emotions and moods, and to problem solve. This then leads to the toddler acting out in aggression or internalizing their feelings.
School-aged	At this age, children who have mothers with postpartum depression often begin to develop anxiety and conduct disorders. In their academic environment, these children are also more likely to experience ADHD, have lower IQ scores, and difficulty in certain school subjects, such as math.
Adolescents	At this stage, children with a depressed parent have increased risk of developing major depression or psychopathology disorders, while also experiencing continued learning disabilities.

Source: Canadian Pediatric Society, 2004; Field, 2011.

depression can disrupt these interactions, and can lead to passive and withdrawn behavioral development of the infant. This pattern continues through adolescence (Canadian Pediatric Society, 2004). Postpartum depression has also been shown to result in inadequate parenting practices that often result in limited to no breastfeeding, and fewer well-child visits and vaccinations (Field, 2011). These are vital components of infant development that improve health outcomes through adolescents. The following table provides descriptions of how postpartum depression impacts child development at varying stages.

More Native Hawaiian mothers experience symptoms of postpartum depression than non-Hawaiian mothers (11.9% vs. 9.7%). Further, Native Hawaiian mākuahine of all ages reported had higher rates of postpartum depression than the state and non-Hawaiians from 2012–2014. Approximately a quarter of Native Hawaiian mothers aged 20 and younger who experience postpartum depression compared to 20% of the State rate.

Risk factors associated with postpartum depression can include personal and familial history of mental health issues; age, income, and education; stressful life events (financial, personal, etc.); lack of familial, social and medical support; complications during pregnancy and/or birth; having multiple babies; or babies requiring medical intervention or are disabled. Mothers who experience healthy pregnancies and a stable lifestyle can also experience postpartum depression (Postpartum Depression Statistics, n.d.; CDC, 2017; Roche, 2015; Schimelpfening, 2017). This research could find no significant correlation to mother's who delivery vaginally compared to having an elective cesarean section. Native Hawaiian births delivered by cesarean section are the lowest in the state at 11.5%, compared to African American women at 18.9%, and compared to the US rate of 26.9% (Hawai'i Health Data Warehouse, 2017). Yet, local research does indicate that "infants born in a primary cesarean were more likely to be premature, low birth weight, and less likely to have initiated breastfeeding (Balihe, Hayes & Fuddy, 2010, p. 1).

Figure 3.10: Postpartum Depression by Mother's Age (2012–2014)

	<20	20–24	25–34	35+	Overall
Native Hawaiian	24.9%	11.2%	10.2%	**	11.9%
non-Hawaiian	**	9.6%	9.9%	9.0%	9.7%
State	20.7%	10.2%	9.9%	9.1%	10.3%

Note: Ethnicity = DOH Race/Ethnicity

**The estimate has been suppressed

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Pregnancy Risk Assessment Monitoring Systems (PRAMS)

Figure 3.11: Breastfeeding [Ever] Rates By Age Group (2010-2014)

	<20	20–24	25–34	35+	Overall
Native Hawaiian	**	96.1%	94.2%	92.0%	94.5%
non-Hawaiian	**	94.0%	96.5%	96.3%	96.1%
State	**	94.9%	95.9%	95.6%	95.6%

Note: Ethnicity = DOH Race/Ethnicity. **The estimate has been suppressed.

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS)

BREASTFEEDING

Traditionally, Hawaiian women breastfed babies as their first food—the waiū (mother's milk)—which was spiritually commenced through wāhine protocols. To initiate an important start to the ho'opēpē period for all mothers, the mawaewae ceremony ensured breast milk let down starting with the right breast (associated with Kū) then the left breast (correlated with Hina). The makuahine maka'āinana (mother of the common populace) takes the kālina (sweet potato vine), wai māpuna (spring water) in a hulilau gourd (receptacle which represents motherhood), faces East toward the lā hiki ola (life-bringing sun) and dedicates herself while saying aloud, “E Ku, e! Ho mai a nui, a mapuna puna, a kahe a wai! O Ku, listen! I want milk for my baby; give me milk in abundance like a bubbling spring, flowing like water” [translation and spelling by Mary Kawena Pukui in Green & Beckwith, 1926b, p. 241]. (Malo, 1903; Green & Beckwith, 1926b; Pukui & Elbert, 1986). Among ali'i and kāhuna families, and for ceremonies of the first born child, Green & Beckwith

(1926b) note more elaborate ceremonies that extend the mawaewae protocols to include special seafood and 'awa to be consumed by the mother. Exquisite description of these customs indicate the integration of spiritual, emotional, and physical well-being of the new mother with observance to abundant natural resources in order for her to be well nourished for the transmission of her milk to her infant.

When a woman experienced difficulties producing waiū, lomilomi was used to stimulate the head of the infant: “If a mother does not have sufficient milk for her baby often they put juice of the roasted sweet potato on top of the [baby's] head. Sometimes they put chewed roasted potato on a piece of cloth and put on its soft spot. The mothers are sure that food is absorbed through this spot because after a cloth full of juice has been placed on the baby's head it very quickly disappears.” (Mrs. Pa, Hā'ena, Kaua'i, July 6, 1931, MS SC Handy, Box 7.1, p. 4, as cited in Chai, 2005, p. 165). Sweet potatoes, 'o'opu (Kyllinga brevifolia) grass, kamanomano (Cenchrus

agrimonioides), and kanawao (*Broussassia pellucida*) were added to a mother's diet to enrich her breast milk (Gutmanis, 1992). Nu'akea is a goddess of mother's milk and lactation prayed to by breastfeeding mothers (Pukui & Elbert, 1964). In *Hawaiian Mythology*, Beckwith (1972) recounts the chiefess named Nu'akea who descended from Māweke of O'ahu (Kalākaua, 1972). Upon her death, Nu'akea was deified and turned into a goddess. "Her name is coupled with Lono in a ceremony performed for weaning boys, called upon at the kuahu (altar) to see the child's prosperity" since he will no longer have the protection of the mana passed from his mother through the waiū (1972, p. 32).

The 'aha'aina ukuhi (Green & Beckwith, 1926b) is the weaning ceremony and feast when the child no longer took waiū, which involved an assessment of the child consisting of various prompts. For example, while facing the East, an 'umeke (bowl) of wai māpuna and two flowers were used to test the child's alignment to Kū or Hina depending on which flower s/he selected (Green & Beckwith, 1926b; Pukui & Elbert, 1986). Kālākaua (1972) and Malo (1903) note the ukuhi is an important ceremony for boys in their societal role, and from various literature sources and translations, it seems apparent that these ceremonies were just as important for the development and alignment of a girl child as she transitioned from babyhood.

Breastfeeding or the use of pumped breast milk exclusively for the first six months, followed by supplemental breastfeeding for at least one year has long been recommended by the American Academy of Pediatrics. Evidence has shown that infants not consuming breast milk have been found to have an increased risk of both common illnesses (e.g., ear infection, diarrhea, and eczema) and life-threatening conditions (e.g., severe lower respiratory infections, necrotizing enter colitis, and sudden infant death syndrome). Infants who did not consume breast milk were also at higher risk for high blood pressure, diabetes (type 1 and type 2), asthma, obesity, childhood leukemia, and lower scores on aptitude tests.

In 2014–2015, the national average of infants having ever been breastfed or [provided breast milk was only 81.1% (CDC, 2016). In Hawai'i, the rates those higher. Additional gains are able to be made among mākuahine. Except for mothers aged 20–24, fewer Native Hawaiian mothers breastfed or provided breast milk to their infant at least

once when compared to non-Hawaiian mothers (2010–2014). The largest breast feeding disparity is among ages 35+ where Native Hawaiian mothers breastfed 4.3% less than non-Hawaiian women.

The largest percentage point difference (4.3) between Native Hawaiian and non-Hawaiian mothers who breastfed or pumped milk for their newborn occurs in mother 35 years of age or older. The highest rates of breastfeeding for Native Hawaiian women were aged 20–24. Future data updates should be provided for Native Hawaiian mothers under the age of 20 in order to get an accurate assessment of breastfeeding rates by duration.

According to the CDC (2016), 60% of mothers stop breastfeeding sooner than they planned. They note that many factors influence how long babies are breastfed during the ho'opēpē phase to include encouragement, state policies, support systems and spaces in the workplace, and community resources who can help when breastfeeding barriers arise. Further research is needed that connects how long a Native Hawaiian infant is breastfed and their reduced risks of asthma, obesity, Type 2 Diabetes, and sudden infant death syndrome as they transition from pēpē to 'ōpio to mākuā. Such long-term tracking can encourage systemic support for successful breastfeeding for longer durations. Among Native Hawaiian mothers, those under the age of 20 had the lowest rates of breastfeeding 9+ weeks (58.8%). Among mākuahine age 35+ breastfeeding 9+ weeks, there is a 15.5 percentage point difference compared to Non-Hawaiian mothers (70.6% vs. 86.1%), respectively.

Maternal and Child Health Interventions

Globally, maternal and infant/child health is a public health concern. It has been estimated that 10 million maternal deaths occurred worldwide between 1990 and 2008, averaging about 500,000 deaths a year. Additionally, nearly four million newborns die within 28 days of birth, while millions of others experience and suffer from disabilities, disease, injury, etc. (United Nations Children's Fund, 2008). Maternal death is defined by the World

Figure 3.12: Breastfeeding Rates, By Duration, By Age Group (2010–2014)

	Duration	Age Group			
		<20	20–24	25–34	35+
Native Hawaiian	Never	**	3.9	5.8	7.9
	<1 week	**	3.9	2.1	**
	1–4 weeks	29.7	16.7	14.5	12.7
	5–8 weeks	**	3.8	5.1	**
	9+ weeks	58.8	71.6	72.5	70.6
non-Hawaiian	Never	**	6.0	3.5	3.6
	<1 week	**	2.5	2.2	1.9
	1–4 weeks	21.7	15.8	9.9	5.7
	5–8 weeks	**	2.9	2.8	2.6
	9+ weeks	65.6	72.8	81.6	86.1
State	Never	**	5.2	4.1	4.4
	<1 week	**	3.1	2.2	1.8
	1–4 weeks	26.2	16.2	11.0	7.0
	5–8 weeks	**	3.2	3.4	3.5
	9+ weeks	61.7	72.3	79.4	83.4

Note: Ethnicity = DOH Race/Ethnicity. **The estimate has been suppressed.

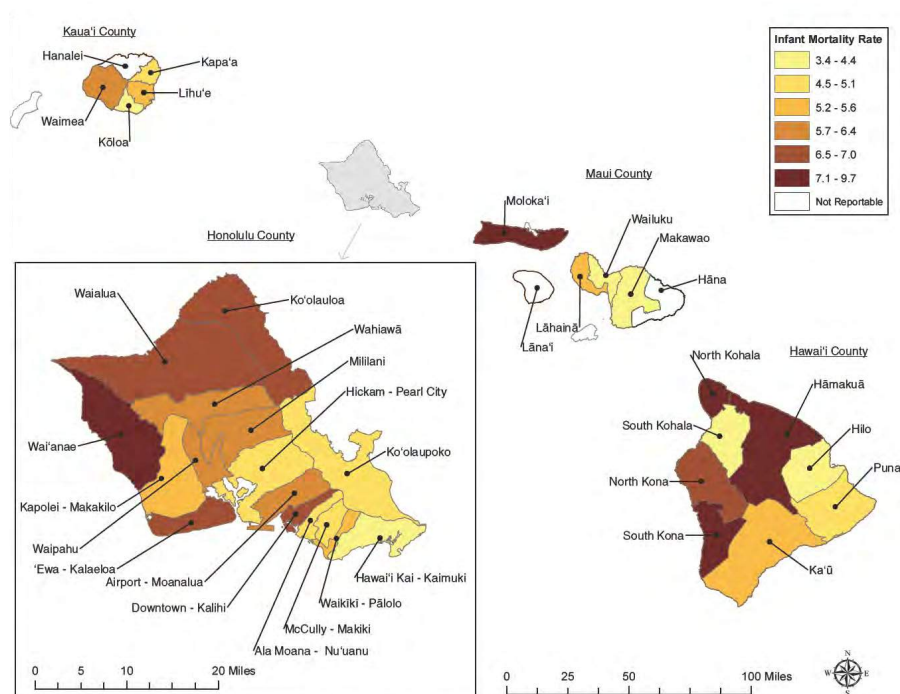
Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS).

Health Organization as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (World Health Organization, 2018).

For Native Hawaiians, this issue has dire numbers, with significant interventions needed to improve the health and well-being of mothers and babies. A 10-year aggregate shows 45% of the extremely preterm births in Hawai'i are born to Native Hawaiian mothers in low income communities (HDOH, 2016, p. 74). These are babies born before 28 weeks gestation. Surprisingly, 33%

of the extremely preterm births in Hawai'i are born to mākuahine in high income communities, which is more than double any other race/ethnicity in the State. When looking at the indicators further, Native Hawaiian women younger than 20 years old make up 63% of extremely preterm births in Hawai'i. Further, Native Hawaiian women younger than 20 years old are 76% of extremely preterm births in Hawai'i in low-income communities (HDOH, 2016).

In addition to premature births, issues related to infant mortality, referred to as the death of an infant before their first birthday, is important to address following the ho'ohānau phase (CDC, 2018). Native Hawaiians have the

Figure 3.13: Map: Infant Mortality Rate (per 1,000) live births by Primary Care Service Area (2016)**Map 4-2: Infant Mortality Rate (per 1,000 live births) by Primary Care Service Area**

Source: State of Hawai'i Primary Care Needs Assessment Data Book 2016, p. 75.

highest rates of infant mortality in Hawai'i—2.3 times greater than Caucasians (HDOH, 2016, p. 74). There are 8 Native Hawaiian infant deaths per 1,000 live births versus 3.5 deaths for Whites in Hawai'i (HDOH, 2016, p. 74). Alarming, this infant mortality rate for k̄naka p̄p̄e is higher than the U.S. rate of 5.9 deaths per 1,000 (CDC, 2018). The Centers for Disease Control (2018) note that preterm birth and low birth weight are among the leading causes of infant mortality, as are maternal pregnancy complications. As you can see from this map, communities with the highest infant mortality rate include Hāmakuā (9.7), North Kohala (9.7), Wai'anae (8.8), Moloka'i (7.7), Ko'olauloa (6.9), and Waimea Kaua'i (6.0) (HDOH, 2016, p. 74).

In order to improve this global, national, and local health burden, it is vital to provide and implement recommendations that work to improve access to quality and affordable family planning, education of healthy lifestyle behaviors, and mental health screening for mothers. The decisions made before and during pregnancy can greatly reduce the health disparities and inequities women and

children face in the future. We can start now by planning with these communities, their health care providers, and organizations who are experts in support services.

EDUCATION

Sexual health education that is age appropriate, medically accurate, stigma-free, and culturally sensitive can enable ōpio to build their relationships and communication skills, empower against gender-based inequalities, promote awareness of gender-based violence among teens, and provide tools for protective practices that improves health outcomes. Family talks with parents and other adult members is a protective measure against high-risk behaviors. The Women's Preventive Services Initiative (WPSI) recommends directed behavioral counseling by a health care provider or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for STIs (Top 12 Causes Of Low Birth Weight In Babies, 2014). On June 16, 2015, the Hawai'i Board of Education passed the Sexual Health

Education Policy 103.5 making sexual health education mandatory in all Hawai'i public schools (Johnson, 2016).

The poor health outcomes associated with unintended pregnancies can often be mitigated by access to quality family planning and pre-/post-natal care for mother and child. By better educating 'ōpio about family planning and birth, there is tremendous opportunity to decrease the rates of unintended pregnancy and improve maternal and infant health outcomes. Educational opportunities are vital in ensuring Native Hawaiians make healthy lifestyle choices for themselves and their babies.

NUTRITION

The first 1,000 days—from conception to two years of age—are critical in terms of how access to highly nutritious foods can affect short- and long-term developmental outcomes. The lack of proper nutrients results in structural brain damage that can lead to impaired motor functions. Further, undernutrition at the infancy stage can lead to cognitive developmental issues that in the

a person's lifespan. By including traditional foods into regular diets and meal planning, we have an opportunity to holistically nourish the future of the lāhui.

During pregnancy, women require approximately 285 additional calories a day, and lactating women require nearly 500 calories more each day. Not only does the caloric intake of women increase, but so does their need for essential micronutrients such as Vitamin A, iron, folic acid, and iodine (United Nations Children's Fund, 2008). Maintenance of such a diet is key in health development of the baby while in the womb. Maternal malnutrition can lead to negative birth outcomes such as low-birth weight, preterm births, and shortened gestation period, while women with high BMI statistics were also at higher risk of preterm birth (Christian et. al, 2015). It is important for women to find a balance between caloric intake and essential nutrients to ensure a healthy gestational period. As presented here, there is ample evidence of vegetables, fruits, carbohydrates, and protein that can enrich a woman's caloric intake throughout every phase. In fact, these foods do not have to be limited to pregnancy but are testaments to superior nutrition across the spectrum of women's health.

BREASTFEEDING

Breast milk is widely acknowledged to be the most complete form of nutrition for most infants, with a range of benefits for their health, growth, immunity, and development (US Department of Health and Human Services, 2000; Chung et. al, 2007). By maintaining this practice, one reduces the risk of mortality among children five years or younger by 19% (World Health Organization, 2013). Breastfeeding has also been shown to optimize the mother's health by decreasing risks for postpartum depression, type 2 diabetes, breast and ovarian cancers. Research has shown that partial- or no efforts to breast-feed are linked to neonatal and post-neonatal risks, as well as "child all cause and cause-specific mortality rates" (Christian et. al, 2015, 366). Lactation practices among Native Hawaiians mothers is an excellent example which is culturally-based and promoted in present day with scientific facts. By increasing exclusive breastfeeding among Native Hawaiian mothers of all ages, there is a tremendous opportunity to integrate levels of well-being and health for mothers and babies.

By including traditional foods into regular diets and meal planning, we have an opportunity to holistically nourish the future of the lāhui.

long-term impact educational attainment and success. This decrease in educational attainment then results in increased chances of experiencing and living in poverty (Victora et. al, 2008). Promoting and encouraging healthy nutritional behaviors in mothers prior to and during pregnancy normalizes healthy eating habits throughout

PARTNER, FAMILY, COMMUNITY PARTICIPATION

In order to address the negative implications of postpartum depression on maternal and child health, it is important that fathers remain actively involved in the child's development and that physicians be increasingly aware of the symptoms of postpartum depression. Supportive loved ones can be one's partner, their extended family, and members of their community. Assisting with the baby during the ho'opēpē period is essential to mothers ability to transition into their new role while acknowledging their own mental and emotional needs. This research found volumes of themes which show 'ohana as collectively apart of the child development process. In fact, positive attributes to this shared kuleana (responsibility) were associated with family decision making protocols as the infant developed into a keiki and then 'ōpio. Cyclically, this is also a protective factor for young children through their adolescents in Hawai'i, who find guidance in supportive family and community environments (Werner & Smith, 1992).

OTHER POLICIES INCLUDE:

- » Implementing maternal mental health screening for prevention and early diagnosis of postpartum depression, and provide support services, including: support groups, buddy systems, family members, partners, etc.
 - » Ensuring coverage of preconception care visit by insurers.
 - » Encouraging exclusive breastfeeding for the first six months of baby's life, then supplementary breastfeeding for two years (per the WHO).
 - » Improving nutritional outcomes and habits of expecting women and new mothers through nutritional courses.
 - » Identifying systems that promote healthy behaviors across the Native Hawaiian population, especially in at-risk families. For example, expansion of home visitation services in low-income communities and areas where disparities are high, including medical care for pregnant women who are homeless or incarcerated.
 - » Enhancing data collection and managing trends, risks, and causes of maternal and infant mortality/morbidity. Such data should be disaggregated by race/ethnicity and made available by county level so that best-practice interventions can be developed to those most in need.
 - » Reporting of these indicators should be regular and freely accessible to the general public for programmatic, policy-setting and community planning.
- » Advancing culture-based programs that provide Native Hawaiian women and girls with high quality reproductive health services. Resourcing should be provided to enable collaboration between community-based efforts with maternal and infant health experts to create safe motherhood programs.
 - » Supporting paid family leave efforts, with a definition of family that is culturally relevant to Native Hawaiian families. This includes practices of adoption and fostering.
 - » Increasing access to family planning service that offers coverage for contraceptives, prenatal vitamins, birth counseling, breastfeeding counseling, and prenatal to postpartum care. In Hawai'i, expand these services in rural communities and primary care settings.
 - » Improving sexual and reproductive health education that promotes safe-sex practices.

Lana Sue Ka'ōpua and Noe Goodyear-Ka'ōpua: What We Pass On To Our Daughters

These excerpts are from a conversation on motherhood and intergenerational health between Lana Sue Ka'ōpua, PhD, DCSW, LSW, her eldest daughter Noe Goodyear-Ka'ōpua, Ph.D., professors at the University of Hawai'i-Mānoa in social work and political science, respectively, and OHA researchers.

ON INFLUENCES

Lana Sue Ka'ōpua (LSK): We have these baby pictures of Noe on a geopolitical tour with us in Waikane Valley. When she was just out of diapers, we were standing with the residents of the Waiahole-Waikane Community Association, camping out for when the police were going to come get the residents.

Noe Goodyear-Ka'ōpua (NGK): As my sister and I were growing up, my mom always called it P.E.—Political Education.

LSK: You get your own sense of what's right and what's wrong and perhaps more importantly what you can do about that.

ON SEXUAL HEALTH AND COMMUNICATION

NGK: Going through puberty, it was so valuable to have a mom who was a professional working with sexual assault survivors; she worked at the Sex Abuse Treatment Center... As I got older, I realized how many of my female friends and classmates, and later students, had been sexually abused, often by people in their lives that they should have been able to trust. I knew girls whose families didn't believe them when they tried to talk about their experiences being violated. I was lucky to come from a family where it was okay to talk about things like sexual assault and rape.

LSK: I didn't look for jobs in sexual health, necessarily. I have always been, like Noe and her sister are, committed to social justice, whatever form that takes. So that was a slice of our life while Noe was growing up. The next



slice of our life, or my life anyway, to which you were all drawn in, was the HIV/AIDS epidemic... You all became a part of that. That wasn't intentional, that wasn't part of raising the kids, but the kids were part of that.

NGK: The other side of sexual health is the sex-positive and open way of celebrating diversities of sexual and gender identities that I got from being raised by you... I think creating a safe space within 'ohana to be able to talk about these issues is important because it certainly has been really valuable in ours.

LSK: We are very lucky to come from a group where women love each other, where women look after each other, where women circle up and talk.

One of the reasons we do this is to celebrate those elders who preceded us, those elders who paved the way for us, those elders who lived in a time when norms and conventions were real different, until what I experienced as a young adult, to Noe's experiences now, to what my grandchildren experience. Part of it is to honor the space that they created for us to be who we are.

NGK: A couple months ago, Hina, my 18-year-old daughter, asked me, 'How do you get me to tell you everything?' I thought: that's something that's been passed on, the openness and direct communication on difficult issues... In addition to having a really strong mom who modeled that for me, I have a really supportive dad. He has always listened to me when I need to talk or struggled with different things. Neither of them enforced any particular gender expectations of me. They supported me in becoming the person that I wanted to become.

ON ELDERS

NGK: Another thing I learned from my mom came from watching her care for elders. She was raised by a single mom, but had a lot of aunties and uncles. When I was a kid seeing some of those uncles get sick, go into the ICU, it was scary. Seeing people that you love age and become incapacitated is hard, but mom approached them with such aloha and grace.

LSK: They gave me so much, it was really such an honor to be able to do that.

ON RECLAIMING WOMEN'S RITUALS

NGK: Our ancestors had clear ways of ritualizing and celebrating all the different aspects of life from birth to death, from a woman's first period, to birthing, death, all the cycles. One of the impacts of colonization has been to strip those away from us.

LSK: We lost a child in between our two daughters. It was a premature fetus, but it was still a baby, and still part of our family. At the time, they would not give me that fetus; they thought it was a health risk. I grieved about this for a long, long time. Part of the reason we had a child 10 years later was because I was in a period of grief—I had not able to somehow acknowledge that this was a real person

from our family who was with us in a different way. We wanted to celebrate their life as well as passing.

Every life—every family life is important no matter what's happened with that person, so in some way I needed that opportunity spiritually to make meaning of that and to be able to lift it up in some way and move on.

NGK: When my mom was hapai with my sister, she took me along to [natural childbirth] class—I really appreciated being included in the preparations. As I became a mom, I started thinking about how to reclaim cultural traditions, such as burying the 'iewe of our kids. For my middle daughter, we homebirthed her with a midwife and later planted her 'iewe. Hina was at the birth too and witnessing it was important.

One ongoing thing that's beautiful is the reclamation of birth traditions and cultural practices. We have yet to fully reclaim or reinvent traditions around a girl's first menstruation—the hale pe'a aspect of our culture. As we are thinking about recommendations for longer term health, it's reclaiming and reinvigorating different ways we honor the different stages of life and rites of becoming.

I would like to see cultural ways of approaching abortion, or dealing with the death of a child. Making sure abortion is legal and continues to be funded is one thing, and there also needs to be a spiritual and cultural network that surrounds us when a woman does make that decision—having a way to honor and celebrate that life, even when you're making a decision to end the pregnancy.

LSK: ...Intergenerational health is the way we've shared information to educate each other, our children and our grandchildren. It's also including kids, using teachable moments and being proactive so they can see different perspectives that they might not have gotten in conventional education.

Incarceration and Intimate Partner Violence

CHAPTER 4

Ke kua a kāmāwail.

The back [guarded by] law.

Said of Pele's back, which was so that to stand behind or approach it was punishable by death. Her back was said to be so hot that a bundle of taro leaves placed on it would cook at once. Her priests, chiefs, and certain of her devotees had a similar kapu—no one was permitted to walk or pass behind them nor wear anything that had been worn upon such a kapu back. ('Ōlelo No'eau, #1757).



Issue Data for Intervention: Intimate Partner Violence & Incarceration

- » Native Hawaiian female youth experience being forced to do sexual activities by their dates and are forced to have sexual intercourse, more than double non-Hawaiian males in Hawai'i
- » Native Hawaiian females experience unwanted sex by an intimate partner 1.5 times more than their non-Hawaiian peers
- » Median age of first arrest for Native Hawaiian women is three years younger than white women and one year older than Native Hawaiian men
- » Native Hawaiians serve more time on probation than all other groups (but Hispanics), when controlling for age, gender, type of charge
- » Native Hawaiian females make up 43.7% of the female incarcerated population in Hawai'i

Introduction

The criminal justice system, as it exists today in Hawai'i, is completely a product of western interventions and laws. Traditional Hawaiian concepts of justice were based on ideas of pono and hewa (right and wrong), where acts of hewa were mistakes, faults, errors, or sins of various degree and offense (Pukui and Elbert, 2003). Faults of your own were punishable, and faults of parents gone unpardoned were inherited by their

children. Therefore, pono behavior and observance of cultural customs created a societal form of justice for lawfulness throughout the districts and fair treatment by the regional leaders. "Hewa ka lima" is the description when a person had done something that was wrong: their hand would show "a disease that remained until he asked for pardon of the person he had injured" (Pukui, 1983). That hewa must be addressed or the "hewa

kumu waiho i keiki, faults of the source are left to the children” (Pukui, 1983) were passed from the parent to child for those wrongs that were committed but redress not performed.

Ka po’e kahiko, although skilled in the arts of warfare, also held principles that life was sacred. Ali’i had mechanisms to protect life, land, seas, and kânaka’s connection with the spiritual realm. Three important ways to protect well-being and preserve the health of the lāhui were: kapu (sacred restrictions), pu’uhonua (places of refuge), and kânāwai (laws).

Today, Native Hawaiian women, in particular, are over-represented in the State prison system—a fact which remains under-explored. We are at a point where these systems have intergenerational repercussions, and we will also explore one of these repercussions: intimate partner violence. Again, Native Hawaiian women are especially vulnerable in this arena—both being the perpetrators and victims of crime—where cycles of trauma reflect systems of abuse against women. This chapter considers the evolution of the incarceration system in Hawai’i, and how it, as a system, has negatively impacted Native Hawaiians, by disconnecting them from their lands and other neocolonial aggressions. Individual acts of aggression against women are paralleled here with systemic forms of violence against kânaka ‘ōiwi.

KAPU

Kapu ordered society and behavior in ka wā kahiko. Both action and inaction were closely monitored by protocols and beliefs. The most common form of punishments for breaking a kapu was misfortune, illness, and death, but it could be escaped if one entered a place of peace and safety or were saved by an ali’i. For instance, a man named Kekuanui and his younger brother were killed for wearing the malo of Kalanimoku (Kamakau, 1996); a woman named Kahinu was burned in fire because it was thought that she smoked from the smoke pipe of Kekuaokalani (Kamakau, 1996). People were also captured if they did something wrong and were, in a sense, taken “prisoner” while they awaited their death.

One of the reasons kapu were in place was to maintain the mana of the ali’i and their divine status. These restrictions governed the behavior of the ali’i while in ceremony and the behavior of the people when around the

ali’i. Hawaiian protocol viewed the mana of the ali’i was so powerful that those who did not possess the same or higher inherited rank must kapu moe (prostrate themselves) or kapu noho (sit) for protection. According to Kepelino (2007), Keohokālōle, Ke’ēlikolani, Pauahi, and Emma were all chiefs of the kapu moe.

Hawaiian akua and ‘aumakua had the ability to use their powers to execute violent forms of punishment for breaking kapu and societal norms. They could cause extreme disruption to one another, to weather, to altering natural resources, and to punishing humans. Physical places for captivity were consecrated to gods and goddesses, and these religious sites also served as both sanctuary or incarceration of one’s spirit.

KĀNĀWAI

Kānāwai were deeply structured in ka wā mamua, to include the akua and the right for them to punish or reward as the supreme rulers of kânaka. An ‘ōlelo no’eau referring to the laws of akua describes “ke kua a kânāwai,” referencing Pele’s back which was so kapu that to stand behind or approach it was punishable by death (Pukui, 1983). Her back was said to be so hot that a bundle of taro leaves placed on it would cook at once. Her priests, chiefs, and certain devotees had a similar kapu—no one was permitted to walk or pass behind them nor wear anything that had been worn upon such a kapu back (Ibid).

In addition, Kānāwai Kolowalu was an ancient kânāwai (law) that could be uttered by a chief to save the life of another. It could be used following battle to cease the killing of those remaining or to save the life of someone who had broken a kapu (Kamakau, 1991b). Kānāwai Māmalahoa was established by Kamehameha I and declared that the elderly and children shall be able to lay safely by the roadside (Kamakau, 1996). This kânāwai was later invoked to spare the lives of warriors on the defeated side of a battle.

PU’UHONUA

Although there weren’t prisons per se, Hawaiians had designated, physical spaces—pu’uhonua, heiau, and others—where kapu and kânāwai are made manifest into sacred spaces of different use.

Pu'uhonua were physical places that people could go to escape death after some type of misdeed occurred. John Papa I'i (1963) named Hale o Keawe or Kaikialealea at Hōnaunau, Kaikihoku and Paka'alana on Hawai'i island, Kakae on Maui, Kūkaniloko at Wahiawā, O'ahu, and Holoholokū at Wailua, Kaua'i are all noted as pu'uhonua. Other places such as Kukuipuka at Waihe'e, Maui, Kualoa on O'ahu and Moku Ola in Hilo may have been other pu'uhonua (Unknown, 1896).

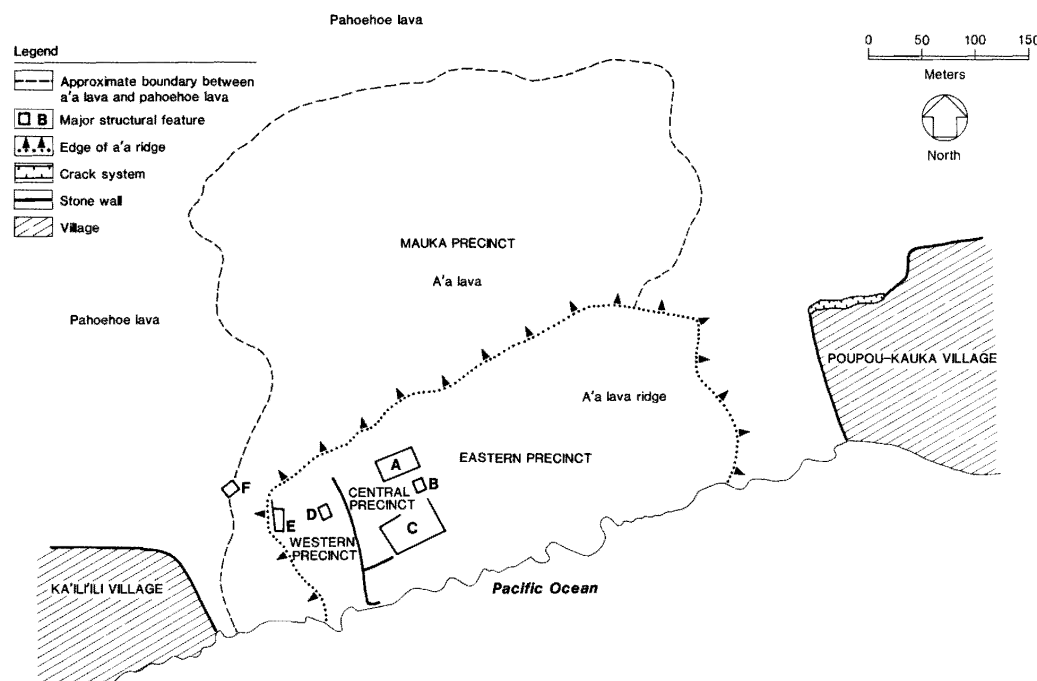
However, the concept of sanctuary in Hawaiian reference is not limited to a dedicated space, but also from kanaka to kanaka. Due to the qualities she possessed, Ka'ahumanu was said to be a pu'uhonua as well as were her many lands on Maui. Noticeably, as referenced in "Motherhood," Holoholokū and Kūkaniloko are also sacred sites for ali'i birthing, not to mention their enshrined power for kapu and kāmāwāi.

In heiau such as Waha'ula Heiau, wāhine served a vital role in the rituals at luakini and the heiau system to include both the Hale o Papa and Hale Pe'a. Waha'ula

Heiau is a luakini (Westervelt, 1915) and a significant religious environment along the seas cliffs in Puna, Hawai'i. "Wahaula was a tabu temple of the very highest rank," where "[t]he heiau was so thoroughly 'tabu,' or 'kapu,' that the smoke of its fires falling upon any of the people or even upon any one of the chiefs was sufficient cause for punishment by death, with the body as a sacrifice to the gods of the temple. These gods were of highest rank among the Hawaiian deities" (Westervelt, 1915).

The system of leadership and sacredness at Waha'ula included the ali'i and kāhuna nui with kāmā and wāhine roles. The 'aha 'ula (council of chiefs) progressed to Waha'ula to assemble for sacred ceremonies at the luakini where rituals were a part of the Hawaiian religion. Waha'ula is built on an 'a'a flow constructed with a series of hierarchical landings, expressed to indicate the mana of that temple. At the first terrace the female members of the royal family brought their offerings to be ritualized by the kāhuna. It is described that no female was allowed to pass beyond the first terrace (Westervelt, 1915). Analyses by Masse, Carter, and Somers (1991) indicate

Figure 4.1: Map of Waha'ula Heiau Complex



Source: Masse, Carter, & Somers, 1991, p. 26.

that some structures relate to wāhine and have been interpreted through archaeology and anthropology as the Hale o Papa and Hale Pe'a within the site environment, likely because of red cinders indicating protocol to the mana of Pele at those structures. "Although the rites in the hale o Papa at the close of a luakini ritual explicitly deal with Pele and her various manifestations (Valeri, 1985, p. 401), it might be that Waha'ula, more than any other luakini, wove Pele into the overall ritual process" (in 1991, p. 45).

In addition, stones with one of the structures appear to be oriented as a kane-wahine pair to Kū and Hina, or more specifically Kū-ka-ōhi'a and Hina-ulu-ōhia (Beckwith, 1970). Female chiefs also worshipped a number of akua, two or three of which were kept in the hale o Papa (see also Valeri, 1985, p. 331), including Kiha-wahine (=Kalamainu'u) and Walinu'u (=Haumea Kameha'ikana), as described by I'i (1983, p. 44) and Malo (1951, p. 82-83). Kiha-wahine and Walinu'u are mo'o deities (Beckwith, 1970, p. 193-195)—ancestral guardians in the form of water spirits. These akua helped rescue a Kaua'i chief named Puna from Pele, and may be represented in this heiau, set up to protect menstruating women from Pele's wrath; likewise, these two stones, or perhaps the other waterworn cobble pair, might somehow be linked with the kapu kai, or the ceremonial seawater purification bath taken at the end of the menstrual period (Masse, Carter & Somers, 1991, p. 45).

Evolution of Incarceration in Hawai'i

For many indigenous people, including Native Hawaiians, the land is central to culture and well-being. Drs. Noa Emmett Aluli and Davianna Pōmaika'i McGregor, respected Hawaiian activists, describe the health of the land and the health of the people as interrelated principles of kanaka well-being (Aluli & McGregor, 1994). Many sacred spaces were created in order to preserve both religious and social harmony. In relation to the penal colonies, quarantine settlements, and imprisonment, Aluli and McGregor indicate that it is not simply the physical removal from the land that is traumatic, but it is the

spiritual loss of the land that is damaging to one's identity as 'ōiwi.

"Arguably, however, one of the most offensive and traumatic ways of alienating a Native Hawaiian person from the land is physically removing them from it and placing them behind bars" (OHA, 2010, p. 63). Kānaka imprisonment in Western carceral systems creates an environment and context where prison prevents Native Hawaiians from practicing traditional Hawaiian religion and their indigenous spirituality connected to the land and the cultural forms of punishment and pardoning, thus perpetuating a cycle of cultural trauma.

The concept of a prisoner—meaning kānaka forcibly removed for their land and families for an extended amount of time—was not common in ka wā kahiko. There were strict penalties for kānaka who violated social and spiritual edicts, and mo'olelo recount that people were captured and usually held while awaiting their death for breaking a kapu. Punishment was often swift and sentencing handed down to fit their infraction.

Upon the arrival of Calvinist Missionaries in 1820, Keōpūolani and Ka'ahumanu were among the first female ali'i to convert to Christianity. Following the death of Kamehameha I and Ka'ahumanu's conversion, she became kuhina nui. She saw to the enactment of social and moral laws in alignment with Christian values, which forbade certain acts such as adultery, murder, and theft (Kuykendall, 1938). The removal of the 'ai kapu, led by wāhine, meant a shift for women during the first part of the 19th century. The 'ai noa and abolition of the kapu system shifted ka wā kahiko into an era of mo'ohihia; resulting in generational entanglements of social and political turmoil as industry and economics shifted the power structure within the ancient hierarchy. This term "mo'ohihia" is used to describe the succession of alterations made to social systems, to include carceral forms of punishment.

Ka'ahumanu II (also known as Kīna'u) was a significant chiefess during the first half of the 19th century. Her role as the Kuhina Nui alongside her brother Kamehameha III brought forth the first penal code in the kingdom era. In 1835, this code ushered in the imposition of a Western judicial system by the Hawaiian monarchy (Silverman, 1982) by also establishing two penal colonies, one on Kaho'olawe for men and one on Lāna'i for women (Thrum, 1903), and the first prisoners were sent to Kaho'olawe in

1826 (King, 1993). Punishment for adultery in missionary-influenced Hawai'i included banishment to the island of Kaho'olawe.

The descriptions of these transitions of new laws moved Hawai'i away from the kapu system of sacred laws from ka wā mamua. The new laws shifted and affected the daily lives of the maka'āinana by punishing common behaviors such as sexual activity, consumption of 'awa, and conducting hula (Osorio, 2002). Osorio (2002) recounts that around 1850, Hawai'i transferred the power from the ali'i and the akua to a legislative form of government. The new legislature was made up largely by American businessmen who were driven by emerging economic interests in the Pacific rather than the welfare of the nation (Silva 2004, OHA, 2010)

Crime and punishment were introduced in the first half of the 19th century. Shortly after, Western style imprisonment developed in Hawai'i following the ali'i's adoption of Christian values and the establishment of penal colonies and prisons throughout the islands. In *The Colonial Carceral and Prison Politics* (2008), Dr. RaeDeen Keahiolalo-Karasuda connects neocolonialism and neocolonial violence to disproportionate punishment of kanaka maoli in the criminal justice system—both remove kanaka from their 'ohana and communities, which also weaken their ability to self-govern. She later traces (2010) a historical root of criminalization and punishment in Hawai'i through the public hanging of Chief Kamanawa II, the grandfather of King Kalākaua and Queen Lili'uokalani. Chief Kamanawa II was accused of murdering his spouse, Kamokuiki for her alleged adultery. The new administration of colonial justice made an example of the chief in the presence of kōnaka witnesses, who were forced to watch his hanging in 1847.

Several years after this first public display of capital punishment, the kingdom legislature passed the first published law regarding public performances of hula in May 1851. Hawaiians of old considered the hula sacred, because it was a means of communication between people and their gods. Because of Laka, goddess of hula, and dance, Hawaiians understand the power of the body to communicate, as well as recognize that dance is the essence of sacred ritual (Kanahele, 1996, p. 96).

However, when hula became outlawed, those who danced hula were criminalized, and the Minister of the Interior had the ability "to license all public shows...to

Western crime and punishment were introduced in the first half of the 19th century.

which admission is obtainable on payment of money... and the chief of police in any town or district where the same shall be exhibited may regulate such show or exhibition in such manner as he shall think necessary for the preservation of order and the public peace" (See Laws, Session, Laws of His Majesty Kamehameha III, passed by the Nobles and Representatives, 1851 [Honolulu; printed by order of the government, 1851] Section 1–2, qtd in Barrere 41). In 1859, a law passed stating the only place one could acquire a license for hula performance was in Honolulu or Lahaina. (See *Civil Code of Hawaiian Islands*. Passed in 1859. [Honolulu: printed for the government, 1859] Ch. 7, Art. 2, Sec. 99, qtd in Barrere 41.) These events from the mid-1800s are just a few examples of a framework that led to numerous transformations to Hawaiian identity and eroded the well-being of a nation and their ola—their way of life.

In 1857, the Oahu Prison was built, its former location a jail made of adobe in Honolulu (Bowser, 1880). By 1893 there were prisons located on O'ahu, Hawai'i, Kaua'i, and Maui.

The rapid rise of capitalism and business interests impressed Western governance, laws and justice on the independent Hawaiian nation. More specifically, the adoption of a Western system shifted governance away from the mō'i, which resulted in severing one aspect of the reciprocal relationship between the ali'i and maka'āinana (Osorio, 2002).

In 1915, a kūpuna wahine named Pulolo was released from Territorial prison in Honolulu after receiving a full pardon from Governor Pinkham. She was described in *The Maui News* as a kahuna from that moku, who was "greatly feared, on the Island of Lanai, where her crimes were committed early in the year 1892" (p. 5). Pulolo was

described to have possessed the powers of a Hawaiian sorceress, which she used to kill three members of her family after a love affair gone wrong. She is said to have uttered a curse in prison to another female inmate, “You will not live 24 hours after you leave prison” (p. 5), and that after the inmate was released she did succumb to an illness. Pulolo was the longest serving prisoner, male or female, at the time of her release (*The Maui News*, 1915). Whether or not this story is true, there were numerous attempts during this time period to discredit and vilify Hawaiians who practices their traditions, especially those who were thought to be evil traditional healers. In 1905, Act 48 was passed which prohibited the practice of medicine without a license, in effort to marginalize them and criminalize their profession (Chun, 2009; Donlin, 2010).

Beyond the penal colonies, another form of banishment came in 1865 when the law, “An Act to Prevent the Spread of Leprosy,” was passed and those thought to have the illness were forcibly removed and sent to the leper settlement at Kalaupapa (Kamehameha IV, 1865, p. 62). for those suffering from Hansen’s disease. Referred to as “ma’i ho’oka’awale ‘ohana,” or “the disease that separates families,” saw thousands of of kākā from all parts of the kingdom removed to Molokai. The act also allowed for the confiscation of property to cover the costs of housing and medical treatment of Hansen’s disease patients. Some Hawaiians refused to go to Kalaupapa and tried to evade capture. Also, babies born to mothers residing in Kalaupapa were taken after birth, and given up for anonymous adoption; hundreds, if not thousands, of infants over the decades, were not provided birth certificates that show their true birth or link to their mo’okū’auhau. Cruelly, many never knew what became of their children; conversely, children never knew the fate of their biological parents.

The new systems of law also introduced forms of punishment that comprised of law enforcement, courts, prison, and parole (OHA, 2010). The imprisonment of Queen Lili’uokalani in January 1895 marked the culmination of a hundred years of foreign imposition in Hawai’i. The Queen’s wrongful imprisonment is one manifestation of a long genealogy of adverse effects of Western law on Native Hawaiians (Queen Lili’uokalani, 1990; Trask, 1993; OHA, 2010).

The Disparate Treatment of Native Hawaiians in the Criminal Justice System compiled information that indicates that Native Hawaiians were not always disproportionately represented in the criminal justice system in Hawai’i. Other immigrant groups, including Japanese, Chinese, Portuguese, and Norwegian people were “generally viewed as a threat and feared by White colonists” (OHA, 2010, p. 23). Based on a sample population of the island of Hawai’i, beginning of the late 18th century until 1945, most of these groups were disproportionately represented as defendants compared to the general population (Merry, 2000). “By contrast, the sample population of the island of Hawai’i showed that Native Hawaiians were disproportionately, underrepresented compared to the general population in the criminal justice system until mid-1900s” (OHA, 2010, p. 23). In addition, first-hand accounts from Native Hawaiians outline concerns with the criminal justice system and how it affects their families and their culture (OHA, 2010).

Contemporary Crime and Arrests in Hawai’i

This report makes an introductory effort to indicate some of the most distressing portions of Hawai’i’s history that remains linked to entanglements today. Contemporary crime and arrests link to injustice and disparities. This chapter includes current statistics which call for more work to be done to address the overrepresentation and disadvantage kākā face in the Western criminal justice system.

ARRESTS: WOMEN

Data on the arrests of Native Hawaiian women is not currently disaggregated in state reports. There is, however, detailed arrest data for women and for Native Hawaiians reported separately. Arrests of women for index crimes accounted for 26.6% of all arrests for index crimes in Hawai’i. Of index crime arrests, women were over-represented in arrests for Larceny Theft (33.0%), Motor Vehicle Theft (25.7%), and Arson (25.0%).

From these data, the follow statistics were revealed:

- » The most common index crime for which women were arrested was Larceny Theft, which accounted for 10.1% of all crimes for which women were arrested
- » Arrests of women for Part II crimes accounted for 24.5% of all arrests for Part II crimes in Hawai'i
- » Of Part II crime arrests, women were over-represented in arrests for:
 - Property Related crimes (26.2%) and
 - Crimes related to Juvenile Status (48.2%).
- » Specifically, women were over-represented in arrests for:
 - Forgery (46.4%)
 - Fraud (32.1%)
 - Embezzlement (65.6%)
 - Marijuana Manufacturing/Sales (26.7%)
 - Opium or Cocaine Possession (26.3%)
 - Marijuana Possession (26.3%)
 - Bookmaking (28.6%)
 - Offenses Against Family/Children (52.9%)
 - Prostitution (65.4%)
 - Suspicion (28.6%)
 - Juvenile Curfew (37.2%), and
 - Juvenile Runaway (49.1%).

The most common Part II crime category for which women were arrested was classified as “Other”, which accounted for 43.5% of all crimes for which women were arrested. The second most common crime category for which women were arrested was Alcohol-Related, which accounted for 15.1% of all crimes for which women were arrested.

Source: State of Hawai'i. Attorney General, 2016.

ARRESTS: HAWAIIAN VS. NON-HAWAIIAN

Crime statistics are available in Hawai'i by gender or by race. Data are not readily available by both; therefore, this report will compare Non-Hawaiian rates with Native Hawaiian. Arrests of Native Hawaiians for index crimes accounted for 31.0% of all arrests for index crimes in Hawai'i.

Of index crime arrests, Native Hawaiians were over-represented in arrests for:

- » Burglary (33.2%)
- » Motor Vehicle Theft (45.0%), and
- » Arson (36.1%).

The most common index crime for which Native Hawaiians were arrested was Larceny Theft, which accounted for 8.1% of all crimes for which Native Hawaiians were arrested. Crimes have been ranked by Native Hawaiian percent in the following table. This data helps us to identify issues and trends in order to better work with the police department, judiciary, and public safety to reduce these rates.

Data from the index crime arrests is one perspective. But is illustrated as a public health concern when able to provide morality data. Figure 4.5 compares the state rates with the U.S. rate for deaths by firearm, homicide, and drug poisoning.

Arrests of Native Hawaiians for Part II crimes accounted for 27.7% of all arrests for Part II crimes in Hawai'i. Of Part II crime arrests, Native Hawaiians were over-represented in arrests for (see Figure 4.2)

- » Violent crimes (28.5%)
- » Drug Manufacturing/Sales (32.7%)
- » Drug Possession (32.0%)
- » Crimes classified as “Other” (29.6%, and crimes related to Juvenile status (34.1%)
- » Specifically, Native Hawaiians were over-represented in arrests for:
 - Negligent Manslaughter (66.7%)
 - Embezzlement (28.1%)
 - Non-narcotic Manufacturing/Sales (39.4%)

Figure 4.2: Hawai'i Index Crime Arrests (2016)

Total	Non-Hawaiian (#)	Non-Hawaiian (%)	Non-Hawaiian % of Total	Native Hawaiian (#)	Native Hawaiian (%)	Native Hawaiian, % of Total	Total (#)
Motor Vehicle Theft	214	55.0%	0.7%	175	45.0%	1.4%	389
Arson	23	63.9%	0.1%	13	36.1%	0.1%	36
Burglary	425	66.8%	1.3%	211	33.2%	1.7%	636
Robbery	205	70.0%	0.6%	88	30.0%	0.7%	293
Larceny—Theft	2358	70.1%	7.4%	1007	29.9%	8.1%	3365
Aggravated Assault	596	70.6%	1.9%	248	29.4%	2.0%	844
Murder	25	71.4%	0.1%	10	28.6%	0.1%	35
Rape	118	78.7%	0.4%	32	21.3%	0.3%	150
Human Trafficking—Commercial Sex Acts	0	0.0%	0.0%	0	0.0%	0.0%	0
Human Trafficking—Involuntary Servitude	0	0.0%	0.0%	0	0.0%	0.0%	0
Total	3964	69.0%	12.5%	1784	31.0%	14.3%	5748

Source: State of Hawai'i. Attorney General, 2016.

Figure 4.3: Hawai'i Mortality Data Comparisons by Indicator (2016)

Indicator	Hawai'i Deaths	Hawai'i Rate**	U.S. Deaths	U.S. Rate***
Firearm Deaths	40	2.6	33390	10.2
Homicide	30	2.2	15809	5.1
Drug Poisoning Deaths	157	10.9	47055	14.7

Note: ** Rates for the U.S. include the District of Columbia and (for births) U.S. territories. *** Death rates are age-adjusted.
Source: Center for Disease Control and Prevention, (2016, June 15).

- Marijuana Possession (30.5%)
- Non-narcotic Possession (35.8%)
- “Other” Gambling (39.0%)
- Offenses Against Family/Children (29.4%)
- Suspicion (28.6%)
- Weapons (34%)
- “Other” Offenses, and Juvenile Runaway (34.1%)

Source: State of Hawai‘i. Attorney General, 2016.

The most common Part II crime category for which Native Hawaiians were arrested was classified as “Other”, which accounted for 47.9% of all crimes for which Native Hawaiians were arrested. The second most common crime category for which Native Hawaiians were arrested was Alcohol-Related, which accounted for 11.5% of all crimes for which Native Hawaiians were arrested.

However:

- » 20.6% (7 of 34) murder victims were Native Hawaiian;
- » 34% (12 of 35) murder victims Female;
- » 23.5% (8 of 34) of known murder offenders were Native Hawaiian;
- » 9% (3 of 34) murder offenders Female.

Source: State of Hawai‘i. Attorney General, 2016.

Contemporary Incarceration

Rates of women in incarceration across the globe are steadily increasing. It is estimated that over 700,000 women and girls are in prison within the U.S., representing 30% of incarcerated women. Reasons for incarceration differ depending on the country. For example, women in El Salvador are often jailed for having miscarriages, as abortions are illegal in that country (Kajstura & Immariageon, n.d.).

There are many adverse impacts incarceration has on a woman’s health. Research has shown that women in prisons have higher rates of substance use than men, and although services are available in jails/prisons to address this issue, they are not often accessed or utilized by the prison population (Freudenberg, 2001). Further, incarceration can impact the mental health of women: evidence suggests that women entering correctional facilities often suffer from mental illnesses such as anxiety, depression, and addiction (Harner & Riley, 2013), and if these women are unable to access necessary services, their conditions are likely to worsen.

Data has shown that in the United States, 41.4% and 45.8% of young adults 24 years or younger in state and federal prisons respectively were parents. Of the State prison population in this age range, 55.4% were women, while 47.5% of those in the federal prison were also women. It is known that incarceration and the separation of mothers from their children has detrimental impacts on family relationships, child development, parenting styles, economic self-sufficiency, and so much more (Bonnie et. al, 2015). In many cases, it is difficult for women reentering their communities after incarceration to find employment, continue their education, and connect with members of their community. There is much opportunity to address substance use and mental instability, which will only increase success of reintegration into the community upon release. When services are implemented and accessed correctly, healing is possible. For example, many incarcerated women long to connect with their children, but the cost of one phone call from a prison is more than most women in this environment can afford (Harner & Riley, 2013). Should the cost decrease and access increase, there is a strong likelihood that women suffering from the stress, depression, and anxiety of being away from their families would decrease.

In the last U.S. Census of 2010, 1,096 women were incarcerated in the state, of whom 479 were Native Hawaiian or 43.7% of the incarcerated population. In the same year, Native Hawaiian women constituted 18.4% of the total state female population, revealing a dramatic over-representation of Native Hawaiian women in the incarcerated population. While Native Hawaiian men constituted 36.2% of the male incarcerated population.

Figure 4.4 looks at the rates of incarcerated women in Hawai'i, compared to the rates of incarcerated wāhine, per 100,000. For example, wāhine aged 30 through 49 are incarcerated at rates more than double the rate of the total women in Hawai'i.

The incarceration rate of Native Hawaiian women is over double that of all women in the state of Hawai'i. In all age groups, the incarceration rate of Native Hawaiian women have higher incarceration rates than the total state, with the exception of the 15 to 19 year age group.

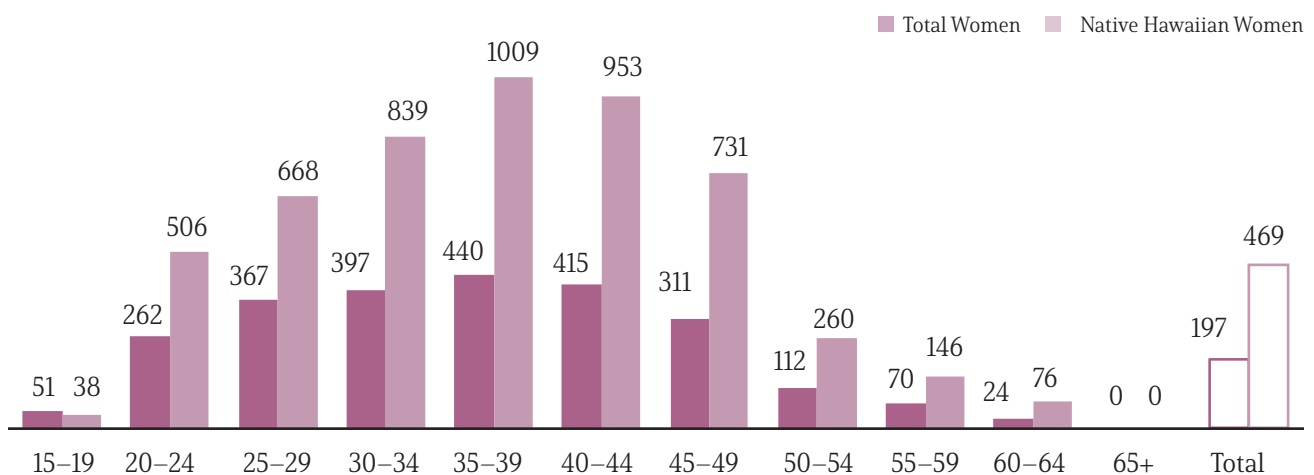
INCARCERATION OF WĀHINE

The current data regarding Native Hawaiians—and especially wāhine—in the criminal justice system are stark. Overall, Native Hawaiians are over-represented in

the Hawai'i prison population. In 2012, Native Hawaiians constituted 18.4% of the total adult population in the State of Hawai'i, but 43.7% of the female prison population Native Hawaiians and 36.2% of the male prison population. Wāhine are over-represented in the prison population to a degree even greater than Native Hawaiian men, even within the highest levels of custody: 42.9% of women in maximum security prison are Native Hawaiian.

These findings are consistent with those of OHA's 2009 *Disparate Treatment of Native Hawaiians in the Criminal Justice System* report, which concluded that while both Native Hawaiian men and women are disproportionately represented in the criminal justice system, the disparity was greater for women. In these data, 44% of incarcerated women were Native Hawaiian, while 37% of incarcerated men were Native Hawaiian.

Figure 4.4: Incarceration Rates of Total Women and Native Hawaiian Women in Hawai'i, by Age Group



Source: U.S. Census Bureau (2010), PC03, Group Quarters Population in Correctional Facilities for Adults by Sex by Age, 2010 Census Summary File 2

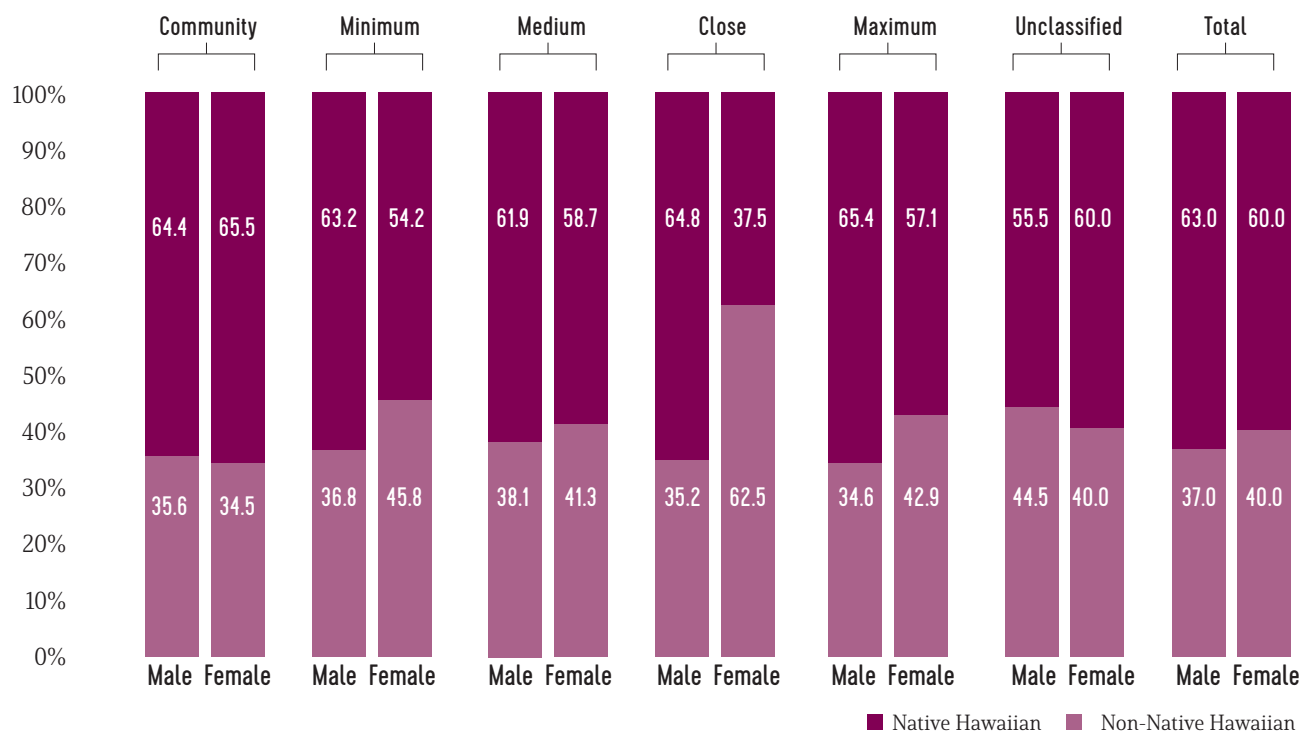
Note: Number of incarcerated women per 100,000 women in that age group.

Further, the incarceration rate of Native Hawaiian women is over double that of all women in the State of Hawai'i. In all age groups, Native Hawaiian women have higher incarceration rates than the total State, with the exception of the 15 to 19 year age group. Wāhine incarceration rates increase through ages 35 to 39 years old, and peak with one Native Hawaiian woman incarcerated out of every one hundred in the State population. The rate then decreases through 65 years and older.

Example Effect: Intimate Partner Violence

Although there are many compounding and complicated effects of Native Hawaiian incarceration and the cycles it can perpetuate, perhaps one of the most visible and sobering is intimate partner violence. According to the Centers for Disease Control and Prevention, “the term

Figure 4.5: Incarceration of Native Hawaiians as A Percentage of the State Prison Population, By Custody Classification and Sex (2012)



Source: Kamehameha Schools, 2014.

Note: The five custody levels shown are defined by the Hawai'i Department of Public Safety (2012) as follows:

Community: “for inmates who have 24 months or less to serve on their sentence and are eligible to participate [in] furlough programs, extended furlough, or residential transitional living facilities.”

Minimum: “for inmates with less than 48 months until their parole eligibility date; who have demonstrated through institutional conduct that they can function with minimal supervision in a correctional setting, or in the community under direct supervision.”

Medium: “for inmates who have more than 48 months to their parole eligibility date; whose institutional conduct and adjustment require frequent supervision/intervention.”

Close: “for those who have minimum sentences of 21 years or more, who are serious escape risks or have chronic behavioral/management problems.”

Maximum: “inmates who are chronically disruptive, violent, predatory or are a threat to the safe operation of a facility.”

‘intimate partner violence’ (IPV) describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy” (CDC, 2017 August 22). Research indicates that there are relationships between treatment, incarceration, and recidivism of offenders and intimate partner violence (Babcock & Steiner, 1999). Risk factors for family violence include children who witness violence while growing up, substance use, low income or unemployment, low educational achievement levels, lack of self-esteem, and histories of sexual aggression (Dutton & Hart, 1992). Therefore, the other chapters in this report should be considered to create a holistic view of the state of IPV within ‘ohana.

It is estimated that one in every five women will experience rape at some point in her life, and one in twenty will experience other sexual violence (Bonnie et.al, 2015). Though these statistics are for young adult women living in the United States, interpersonal, domestic, and sexual violence are global public health concerns. Generally, women in this age range experience the highest rates of interpersonal and sexual related violence than any other age group. Evidence has shown that 47.1% of women who experience intimate partner violence, rape, or stalking are between the ages of 18 and 24. These statistics are a stark contrast to what women of other ages experience, and men experience, across all ages.

Figure 4.6: Types of Overrepresentation

ISSUE	DATA
Arrest	Median age of first arrest for Native Hawaiian women (31.65) is three years younger than white women (34.91) and 1 year older than Native Hawaiian men (30.59)
Pretrial Detention	33% of pretrial admissions in 2009 were Native Hawaiian, compared to 24% of the total State population in that year
Admission into Custody	36.3% of those admitted into custody were Native Hawaiian (2009)
Probation	40% of those sent to prison for probation violation are Native Hawaiian (2009) Native Hawaiians serve more time on probation than all other groups (but Hispanics), when controlling for age, gender, type of charge
Sentencing	Native Hawaiians are more likely to receive longer prison sentencing than all other groups (but Native Americans), when controlling for age, gender, type of charge

Source: OHA, 2010.

IPV AND WĀHINE

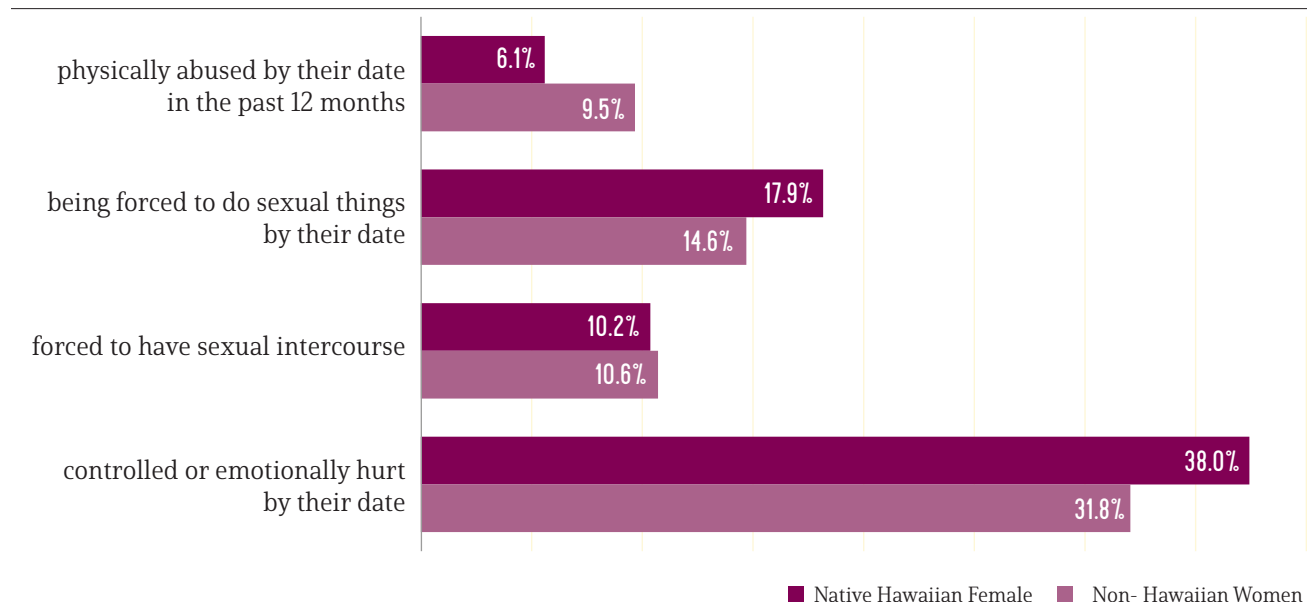
In Hawai‘i, intimate partner violence takes many forms, and especially among our youth, the data can be upsetting. Native Hawaiian female ‘ōpio in high school (17.9%) experience being forced to do sexual things by their date more than double non-Hawaiian males in the State (8.5%). Further, adolescent females in the State are forced to have sexual intercourse 68% more than non-Hawaiian males.

In addition, nearly 25% of Native Hawaiian and Non-Hawaiian male youths experience being controlled or emotional hurt by their date—but 38% of Native Hawaiian female youth experience the same type of

violence in high school. Inversely, 6.1% of Native Hawaiian girls in high school reported being physically abused by their date in the past 12 months, which is less than half of non-Hawaiian boys (13.7%), with another 11.1% of ‘ōpio kāne physically abused by their partner in high school.

Among adults, 17.8% of Native Hawaiian women experience IPV in their lifetimes, compared with 11.4% of non-Hawaiian women. Combined, this is 50,000 adult women in Hawai‘i whose mental and emotional needs are risked due to intimate partner violence. While the data is five years old, Figure 4.8 and 4.9 are included in this report in order to recommend ongoing monitoring and tracking. With updated data, better programs and policies can be informed by the best information available.

Figure 4.7: Percent of High School Population in the State of Hawai‘i to Experience Intimate Partner Violence (2015)



Note: Data reported are “statistically stable” based on the relative standard error of below 0.30 and the count or rate may be considered stable. Data on item “forced to do sexual things were not collected in 2017. Most recent results from 2015 are reported. Ethnicity = DOH Race/Ethnicity
Source: Hawai‘i Health Data Warehouse, State of Hawai‘i, Hawai‘i School Health Survey: Youth Risk. 2017. (Report Created: 1/23/2017)

Figure 4.8: Percent of Adult Population in the State of Hawai'i to Experience Intimate Partner Violence (2013)

	Total Population % / (estimated count)	Female % / (estimated count)
Native Hawaiian	12.60% (11,500)	17.80% (7,800)
Non-Hawaiian	9.10% (67,700)	11.40% (43,500)

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS). (Report Created: 12/7/2017)

Figure 4.9: Percent of the Female Adult Population in the State of Hawai'i to Experience Intimate Partner Violence, by Age (2013)

Women % / (estimated count)	18–29 years old	30–44 years old	45–59 years old	60+ years old
Native Hawaiian	20.60% (2,600)	19.60% (2,400)	21.00% (2,300)	n/r
Non-Hawaiian	13.30% (9,400)	13.30% (12,400)	12.60% (12,600)	n/r

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS). (Report Created: 12/7/2017)

Moreover, Native Hawaiian women appear to experience IPV early in their lives, as 20.6% of Native Hawaiian women ages 18 to 29 years old report experiencing IPV, compared with 13.3% of non-Hawaiian women of the same age range. Here, we can start to understand the connection between IPV in high school girl's grades 9–12, and rates among young adults aged 18–29. The most disparate rates of IPV are experienced 50% higher by wāhine aged 45–59 years old than non-Hawaiian women (12.60% vs. 21.00%).

9.0% of Native Hawaiian women experience unwanted sex by an intimate partner in their lifetimes, compared with 6.0% of non-Hawaiian women. 19.3% of Native Hawaiian women have experienced unwanted sex or physical abuse by an intimate partner, compared to 7.9%

of Native Hawaiian men and 13.4% of non-Hawaiian women. The last data available on Native Hawaiian women's experience of IPV were collected by the Department of Health in 2013. Due to funding shortages, these data on no longer collected through the Hawai'i Behavioral Risk Factor Surveillance System (BRFSS). This report recommends continuing this data collection and reporting so that public health intervention and prevention services can be better informed.

4.8% of Native Hawaiian women who recently gave birth experienced physical abuse by their husband or partner during the 12 months before their pregnancy, compared to 1.7% of non-Hawaiian women who recently gave birth. This is 95% decrease from before birth to during birth, shown in Figure 4.11.

Figure 4.10: Percent of Adult Population in the State of Hawai'i to Experience Unwanted Sex by Intimate Partner (2013)

	Total Population % / (estimated count)	Female % / (estimated count)
Native Hawaiian	4.70% (4,300)	9.00% (3,900)
Non-Hawaiian	3.40% (25,600)	6.00% (22,700)

Note: Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS).

(Report Created: 12/7/2017)

Figure 4.11: Percent of New Mothers in the State of Hawai'i to Experience Intimate Partner Violence (2017)

FEMALES	Physical Abuse <u>Before</u> Pregnancy	Physical Abuse <u>During</u> Pregnancy
Native Hawaiian	4.80%	1.70%
Non-Hawaiian	3.80%	1.80%

Note: Data reported are "statistically stable" based on the relative standard error of below 0.30 and the count or rate may be considered stable.

Ethnicity = DOH Race/Ethnicity

Source: Hawai'i Health Data Warehouse. (2017). Hawai'i Department of Health, Behavioral Risk Factor Surveillance Survey (BRFSS).

INSTITUTIONAL EXAMPLE: UNIVERSITY OF HAWAII SYSTEM

In January 2018, the University of Hawai'i (UH) System Office Of Institutional Equity released their *Campus Climate Survey on Sexual Harassment and Gender-Based Violence* (2017). This survey was "designed to estimate the prevalence of the following four types of gender-based violence experienced by our students both on and off campus: sexual harassment, intimate partner violence (domestic and dating violence), stalking, and non-consensual sexual contact." Gender-based violence was measured any time while a student was enrolled at UH, to include experiences both on and off campus.

For female undergraduate participants reporting sexual harassment (including multiple selections), 25.4% of offenders were faculty or staff and 85.1% of offenders were UH students. For female graduate participants, 52.6% of offenders were faculty or staff and 68.7% were

UH students. In addition, Native Hawaiian (5.3%) survey participants were statistically more likely to report experiencing non-consensual sexual contact compared to Filipinos (3.3%) (University of Hawai'i System Office Of Institutional Equity, 2017).

The survey found higher rates of sexual harassment, stalking, dating and domestic violence, and non-consensual sexual contact reported by the following characteristics:

- » Female undergraduates
- » Native Hawaiian students
- » Transgender/genderqueer/questioning or non-conforming (TGQN) students

- » Lesbian/gay/bisexual/questioning/not listed (LGBN) students
- » Students with disabilities
- » Students living on campus; and
- » Students at four-year campuses (as opposed to two-year campuses).

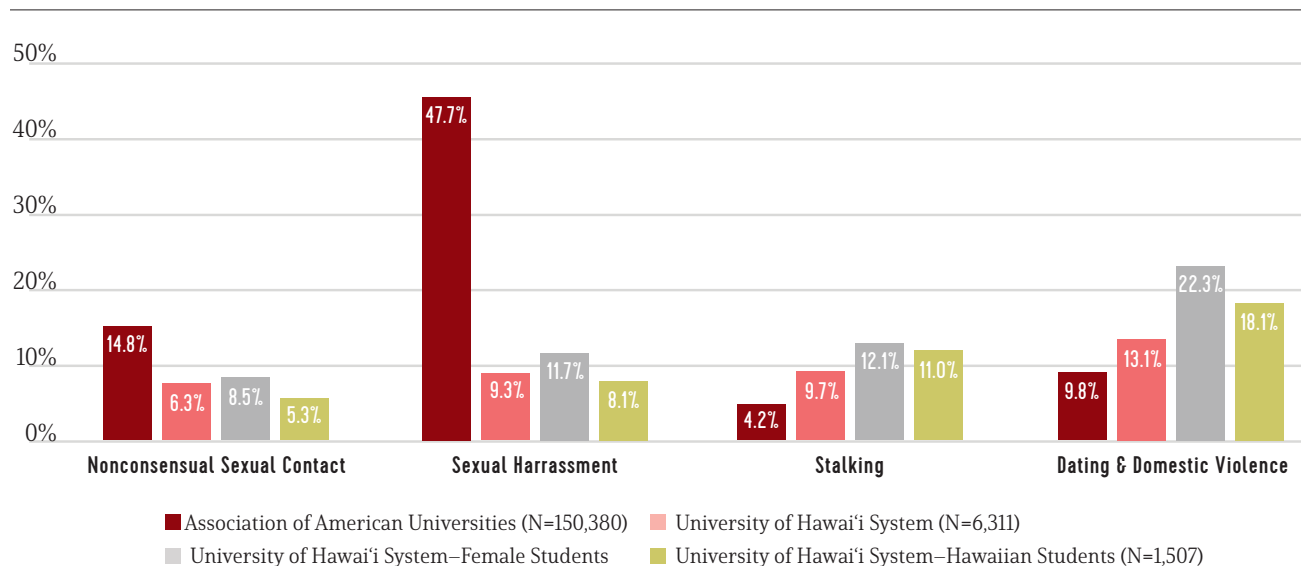
These patterns are similar to national campus surveys, with the exception of Native Hawaiian students, for whom there is no comparable national data (University of Hawai'i System Office Of Institutional Equity, 2017).

Interventions & Recommendations

To have a more complete understanding of the impact of incarceration on the Native Hawaiian people, additional research and community collaboration should untangle

cycles of violence and trauma. Discussing the connections of abuse and family violence is an important place to start when looking at the historical progression of oppressive systems. “Investigating the criminalization and incarceration of Hawaiians from a political perspective provides an opportunity to unravel myths advanced over time about the criminality of Hawaiians” (Keahiolalo-Karasuda, 2010, p. 148). In order to develop recommendations that will work to reduce racial disparities in the justice system, “there must be an understanding of the historical trauma associated with the loss of land, language and religion through contact with Western civilization” (OHA, 2010, p. 24). Historical trauma manifests itself in a variety of ways, but most notably for The Disparate Treatment of Native Hawaiians in the Criminal Justice, it includes substance abuse. (See Physical and Mental Health chapters). That report picks up from historical events and provides recommendations to reduce the unfair impact of the justice system on Native Hawaiians, including: reform the State criminal justice system to embrace the cultural values of Native Hawaiians; develop a targeted plan to reduce racial disparities; and formulate policies and procedures to eliminate the disparate treatment of Native Hawaiians. It should be considered in conjunction with this chapter.

Figure 4.12: Comparing Type of Gender Violence at the University of Hawai'i System (2017)



Note: Data not available for Native Hawaiian Female Students in Combination. UH Survey questions were not identical to AAU Survey questions
Original Data Source: University of Hawai'i System Office Of Institutional Equity (2017).

Further, to successfully intervene for Native Hawaiians in regards to IPV, a shift may need to focus on strengthening relational connections with self, other, spirit, natural elements, cultural practices and community at large (Oneha, Magnussen, & Shultz, 2012). In a 2003 review of records from four community health centers in Hawaii, 32.3% of documented reports of IPV were made by Native Hawaiian women as self-identified in medical record documentation (Ibid). Only a small percentage of this abuse is reported to the police. Therefore, many communities offer additional clinical interventions. However, a community based participatory research study conducted in 2012 found that intervention strategies are commonly based on Western notions of family life (Ibid). This study suggests that Native Hawaiian women may view IPV as a “family matter” which should not be dealt with external to the family context (Ibid). Thus, cultural processes within families like pule ‘ohana, cleansing and ho’oponopono might be an area for future research and prevention planning in Native Hawaiian families.

Further, the use of media to portray another side of IPV and incarceration is needed in Hawai‘i. Using public service announcements like “Hawai‘i Says No More” is a great way to include local leaders who are recognizable by the community and who take a stand against violence in Hawai‘i. Local leadership’s voice to issues like domestic violence and sexual assault create a value-system for the community to respond to as a mechanism to incite awareness for topics that may be difficult to discuss within families.

Young adult policies should address and include the following:

- » Disaggregate data by age, race, and gender to better understand social contexts of violence against women for all age groups.
- » Introduce and implement policies that address the gender wage gap.
- » Educate health providers of how best to manage and address reported cases of abuse or any type of violence. Providers could be trained to provide counseling, screening, and patient navigation to appropriate services and resources.
- » Explore diversion programs with ‘ōpio. Funding should be specific to Native Hawaiian programming to establish local best practices interventions
- » Enhance programming in places like Kaho‘olawe which serve as sanctuaries of contemporary healing (Aluli & McGregor, 1994)
- » Identify and support current Hawaiian-specific programs that focus on reducing offenses and re-offending. This should include ho’oponopono for families who seek cultural practices to address emotional turmoil in their lives for prevention through reintegration.
- » Detailed recommendations are needed from experts in criminal justice and judiciary systems who are familiar with reducing the disproportionate rate of incarcerated Native Hawaiians.
 - The State of Hawai‘i should develop statewide criminal justice targets to reduce the rate of incarceration of Native Hawaiians (men, women, and youth) and violence against them.
 - Community-led and place-based initiatives should be developed and resourced.
 - The State of Hawai‘i should examine legislation which imposes mandatory or presumptive terms of imprisonment upon conviction of an offender that has a disproportionate impact on Native Hawaiians.
 - Create community-based sentencing options that are culturally appropriate for Native Hawaiians for certain classes of arrests.
- » Policies that address mākuā health programs should include: Interpersonal and domestic violence screening and counseling.
- » Screening and assessment of the trauma and impact caregiving places on women. The responsibility often falls to the women in the family to provide care to ageing parents, aunties, uncles, etc., which can result in added stress (financially, mentally, emotionally).
- » Hawai‘i’s civil protection orders could be improved to better support survivors of violence (Anderson and Williams-Baron, 2017, p. 31)

Restorative Justice: Bringing Connection and Healing to Our Pa‘ahao

Ashley Soares first fell in love with hula when she was seven years old. “From the time I saw my cousins onstage for Keiki Hula, I knew that’s what I wanted to do,” she remembers.

And she did practice hula growing up. Unfortunately, she also grew up with abuse within her ‘ohana—physical, sexual, and substance abuse—and, as she got older, she became involved in “unhealthy relationships” and behaviors. An inmate at the Women’s Correctional Correctional Center (WCCC) since 2011, Soares and her experiences are just one example of what has been echoed in others: abuse can be intergenerational and can be related to incarceration, but cultural connections along with community connectiveness can make a positive change.

Previous WCCC administrators had asked Soares to teach hula to other inmates, but since she didn’t ‘uniki and wasn’t a kumu hula, Soares said it didn’t feel right, and so “we were just learning dances.” That feeling changed 2014, when Malina Kaulukukui retired from working at the University of Hawai‘i School of Social Work and Salvation Army’s Women’s Way and volunteered to teach hula at the prison. Kaulukukui is a social worker by training, and in addition to her work in ho‘oponopono, treatment programs for wāhine, teaching, and other mental health work, she danced hula under Maiki Aiu Lake and Mae Kamamalu Klein and studied under Kumu Hula Pohai Souza. She achieved her ‘uniki in 2008 and now teaches in her own halau.

“When I proposed it to [WCCC administrators], I called it Hula as Healing,” Kaulukukui says. Not only do they learn how to dance different kahiko and auana and give voice to different mele, inmates in the “inside Halau,” as they refer to it, also explore themes of power and control in both different mele and oli, and their own lives, for the inmates’ healing.

Because we live in a colonized culture, says Kaulukukui, issues of power and control are at the heart of so many issues—including abuse. “There are so many power imbalances, especially for Native Hawaiian women. So, for example, we talk about Pele, and her strengths, and then also look at her sister, Hi‘iaka, and how Pele exercised control over her, sometimes destructively,” she notes. “By examining these mo‘olelo and how they can relate to their own lives, they are able to gain perspective on their pasts and move towards healing. We have to arm our women with skills and choices that make sense culturally. Here, we happen to use hula. They are also expected to demonstrate discipline and caring for their hula sisters.

“I tell the women I want them to know their own na‘au—standing in my own truth, knowing my own na‘au, has to come first. Once you have that you can start to heal,” Kaulukukui says. Soares agrees, “Finding hula again, in here, has grounded me. When I dance, nothing else matters. It’s part of me learning to love myself first.”

WCCC Offender Services Administrator Nicole Fernandez says they want the emphasis for these women to be on healing. “They’ve already been punished by the judge giving them their sentence to prison, taking them away from their families and communities—we don’t need to punish them further,” she thinks. “If restorative justice is a long line, then we are at the far end, and by the time they get to us, they have had gone through many other things already, so we want to focus on healing—not just their own healing, but healing of the community and culture that has gotten these women here in the first place. So part of what we do is help with rehabilitative services so that the women are prepared when they are released from prison. At the end of the day, they are members of our community—just like you and I.”

Fernandez has noticed some things in her eight years at WCCC: first, she’s struck by what seems like younger and younger women being incarcerated. Also, for mothers, Fernandez has watched their children age through visits, which means they are growing up apart from their mothers. “I’ve literally watched these children grow up,” she notes. “It really hit me with the reality of it, of how many people are negatively affected by this system.”

In addition, Kaulukukui says that there’s a stigma—men can go into prison as individuals, but if you have children, women are labeled “bad mothers.” She wants greater choices for family healing, such as ho’oponopono for those who want it, so that these women’s relationships are in a healthier place when and if they get out of prison. They would also like if there was a program where inmates with toddlers or babies can have them in the correctional facility.



For her part, Ashley is trying her best to maintain a relationship with her two daughters, choreographing a hula for her elder daughter to audition for May Day queen, and using her phone time to help with homework. She also is Kaulukukui’s class “alaka’i,” the person who has the kuleana (responsibility) of preparing the classroom, organizing the others, and making sure basic hula protocols are followed. If she can’t be present, Ashley arranges for another assistant to help Kaulukukui with the class. “I can see something internally happening with Ashley,” Fernandez says. “She’s finding her voice, not just culturally, but who she is: her self-worth.”

Economic Well-Being

CHAPTER 5

Hā'awe i ke kua; hi'i ke alo.

A burden on the back; a babe in the arms.

Said of a hardworking woman who carries a load on her back and a baby in her arms.

(‘Ōlelo No’eau, #401)



Issue Data for Intervention: Economic Well-Being

- » 28% of Native Hawaiian families were single-mother households, and 11% were single-father.
- » Of all businesses owned by women in Hawai‘i, only 11.3% are owned by Native Hawaiian females.
- » Native Hawaiian women are paid 71 cents for every dollar Caucasian men in Hawai‘i get paid, and 82 cents on the dollar that Native Hawaiian men get paid.
- » Less than half of wāhine are represented in computer and mathematical positions (0.4%), compared to kāne (1.1%)—both who are out represented by statewide females (1.2%).
- » The age of greatest disparity for poverty among Hawaiian women is aged 25–34 (18.8%), which is more than 10 percentage points higher than non-Hawaiian males of the same age (8.1%). Further, wāhine poverty rates aged 35–44 are double (15.3%) than non-Hawaiian males (7.3%) during this range.

Wealth o ka Wā Mamua

Prosperous kānaka maoli industries brought generations of productivity, subsistence, growth, and material contributions across the pae ‘āina and throughout Oceania. Asset development and management was a critical kuleana of the konohiki and the exchange between maka‘āinana, the akua, and the ‘āina. The bounty of these traditional practices sustained the lāhui, and balanced the mana of humans with their natural environment. In this chapter, we seek to elucidate strategies that have always—and should continue to be invested within—promoted an indigenous approach to economic self-sufficiency which upon examination, draws significant parallels to job training, career readiness, expertise development and increased access to opportunity. The connections between these approaches should be vital considerations when planning for the pae ‘āina long-term, and when designing recommendations for the entire lāhui.

As a foundation of economic activity in ancient Hawaiian society, agriculture allowed kānaka to sustain themselves, their ‘ohana (families), and their communities. Because

wai (fresh water) was vital, for consumption, agriculture, and aquaculture, it was valued above all other resources in ancient Hawai'i. Native Hawaiian historian David Malo (1951) suggests that centrality of water in Hawaiian society was reflected in the Native Hawaiian understandings of the different uses and types of water. The importance of wai in Hawaiian conceptualization becomes especially apparent when considering that “waiwai,” the Hawaiian word for wealth or prosperity is derived from the same word for water: a person who had access to fresh water was considered to be a wealthy person (Pukui, 1986; Kanahele, 1986). Although pre-contact Native Hawaiians valued wai as a source of wealth, access to clean drinking water was understood to be a right of all individuals in society. It is this idea of wealth that is linked to an abundance of natural resources toward the healthiness of the ‘āina and sustaining the well-being of people generation after generation.

TRADITIONAL VOCATIONS

In ka wa kahiko, wāhine held numerous physical, emotional, spiritual, and cognitive roles that contributed to a flourishing society from mauka to makai. Native Hawaiian historian Samuel Kamakau (1996) notes that kāne generally did most of the farming, making imu, and fishing, and wāhine mainly managed the work inside the hale. However, on Maui and Hawai'i islands, the work of kāne and wāhine were said to be equitable.

In the hale kuku, wāhine pounded clothing out of kapa (barkcloth) for themselves and their ‘ohana. These included kihei (a covering for the upper body), malo (loincloth) for the kāne and keiki kāne, and pa‘ū (skirt covering the lower body) for the wāhine and kaikamāhine (Malo, 1903). Kapa making in Hawai'i was distinguished from other kapa in the Pacific by the use of the watermark and ‘ohe kāpala (bamboo stamp) (Buck, 1957). These markings encrypted genealogy, legends, and artistic interpretations that capture the kaona (double meanings), beyond aesthetics and toward spiritual adornment. This was but one of the trades that wāhine oversaw in their roles and responsibilities and describes female leaders within a flourishing Hawaiian economy. Other advanced technical skills included the intricate weaving of pillows, blankets, and mats often made of hala (pandanus) leaves.

On the ocean and near the sea, wāhine were primarily engaged in reef fishing which they accomplished with scoop nets and fish baskets (Titcomb, 1969). Kalamainu'u was the female mo'o god of basket trap making (Buck, 1957) said to reside in a cave at Makaleha, Lā'ie and to whom bodies were dedicated to become mo'o (Beckwith, 1970). Like Kalamainu'u, wāhine participated in the twisting of the olonā fibers that went into creating deep-sea fishing nets to capture larger seafood. However, once the net was completed and dedicated in ceremony, they were only used by kāne who then took them out onto the wa'a (Handy & Pukui, 1972). This example indicates a balance and shared kuleana between kāne and wāhine that brought forth greater abundance through harmony. Margaret Titcomb (1969) noted certain skilled wāhine fisherman:

There were people so lucky in fishing that they were said to have skins like Ku'ula (‘ili Ku'ula). If there were such persons in a locality only they were allowed to dive into the water with hinana nets. No others went into the water at that time, for that would counteract the influence or mana of the diver. If there were only one such person she had to go alone. Strangely, all the ‘ili Ku'ula people I knew were women (p. 123).

Other activities that wāhine engaged in near the ocean was salt-gathering known as hāhāpa'akai (Malo, 1903; Pukui & Elbert, 1971). Salt could be gathered from kāheka, which are pools in the reef where salt water washes in and naturally dries to form salt or it could be cultivated in lo'i as is done at Hanapēpē, Kaua'i. From the upland streams, wāhine also gathered ‘o'opu (Hawaiian goby), ‘opae (shrimp), and hihīwai (freshwater limpet) (Titcomb, 1969). ‘O'opu and other common fish were also raised in ponds known as hana lawai'a. Ka'ahumanu was said to have had a large pond in Waipi'o Valley that was dedicated solely to ‘o'opu (Titcomb, 123). The ‘o'opu of Waipi'o were famously called the “‘o'opu ‘ai lehua o Hi'ilawe,” or “the ‘o'opu that eats the lehua blossoms of Hi'ilawe” and ‘o'opu was very common and ‘ono (delicious) (Maly, p. 165).

Although kapu were prevalent in every aspect of Hawaiian life, it is important to note that there were certain places that were free of kapu. One such place was the hale noa, which was the common dwelling house where men and women could freely interact. There were also places that were consecrated for the exclusive use of

women. These places helped to reinforce female mana, strengthen relationships with female deities, and provide the opportunity to gain the support of female relations. This close female pilina with the spiritual realm ensured the wellness of female relationships; therefore, it was important to foster them.

HE AUPUNI PALAPALA

According to Pukui, children were taught different trades and skills by their kūpuna, who were knowledgeable and the “logical teachers for the young” (Pukui, 1942). Following the coming of Christianity in the 19th Century, the rise of literacy, and the spread of a Western-centric school system, education shifted outside of learning that began within the hale with the wāhine towards classroom governed by reverends and their wives. The aliʻi greatly supported this form of education and sought to give their people opportunities to embrace new tools and opportunities to advance the kingdom. As more malihini immigrated to Hawaiʻi, ʻōiwi acculturated certain Western ideas and values as useful tools in the rapidly shifting modern era, including written language.

In 1820, shortly after Liholiho became mōʻī, the American Board of Commissioners for Foreign Missions came to Hawaiʻi from Boston, Massachusetts; he allowed them to stay in the kingdom under the condition that they teach the aliʻi how to read and write. Missionaries helped develop the Hawaiian alphabet and translated the Bible in English, Latin, and Hawaiian—and this single mechanism played an instrumental role in accelerating the loss of the Hawaiians’ religious structure and belief system, and moved Hawaiian society toward Christianity. Western-style education was growing, and by 1831 over a thousand schools were built across Hawaiʻi (Laimana, 2011). Hawaiʻi was also the first country to require compulsory education, and during this time, Hawaiʻi became one of the most literate nations in the world with about 90% of people able to read and write (Laimana, 2011).

When Kamehameha III became mōʻī at the age of ten as King Kamehameha III, he followed his brother Liholiho’s support of education, proclaiming “he aupuni palapala koʻu” or “my nation is a literate nation” (Kamakau,

2001). Concurrently, an enormous volume of Hawaiian language newspapers were produced, which resulted in about 125,000 Hawaiian language newspaper pages (Nogelmeier, 2010). The earliest printing was produced on February 14, 1834 at Lahainaluna on Maui in the student nūpepa, *Ka Lama Hawaiʻi* (Ibid). Printed materials with ʻōiwi and malihini readers brought forth a platform for trade and a mercantile economy that expanded the Kingdom’s presence across the Pacific and around the world.

King Kalākaua further supported ʻōiwi excellence in education by establishing a program that supported ʻōiwi to study abroad in 1880 (Quigg, 1988). Two acts appropriated government funds: the first, for “Education of Hawaiian Youths in Foreign Countries, to be expended in the actual education of the youths, and not traveling and sight seeing,” was established in 1880, and the second act in 1890 was entitled “To Provide for and to regulate the sending of Hawaiian Youths Abroad to be Educated.” Eleven students were hand selected by King Kalākaua for this program. The only wahine chosen for the program, Maile Nowlein, studied art and music in Italy, while Robert William Kalanihiapo Wilcox attended a military academy there (Quigg, 1988; Liliʻuokalani, 1990). Kalākaua’s program was scaled back when he was criticized for excessive spending.

Several years later, Queen Liliʻuokalani noted the value of educating young wāhine and established the Liliʻuokalani Educational Society in 1886. It was known as the Hui Hoʻonaʻauʻao and awarded educational scholarships to young women whose families could not afford to send them to school (Liliʻuokalani, 1990), but was discontinued with the illegal overthrow of the Hawaiian Kingdom in 1893.

Another aliʻi wahine and granddaughter of Kamehameha I, Bernice Pauahi Bishop, established a trust from her lands that she largely inherited from her female relative, Keʻēlikolani, to fund a school to educate Native Hawaiian students, and called the Kamehameha Schools. Today, Kamehameha Schools supports the education of Native Hawaiians not only through their campuses, but also through scholarships for students attending preschool and college (see Leadership and Civic Engagement chapter).

Diversified Industry and Economics in Hawai‘i

The arrival of the Euro-American explorers and traders to Hawai‘i in the late 1700s instigated an influx of people, technologies, and concepts that greatly altered Hawaiian society; many of these changes affected the beliefs and practices surrounding the traditional Native Hawaiian economy and had far-reaching effects on Hawaiian self-sufficiency beyond those traditional vocations presented (Shoemaker, 1965). Commercial activity of sandalwood, whaling, sugar, and pineapple (see figure 1) were not the only impetus for economic change in Hawai‘i during the nineteenth century.

As described in the “Motherhood” chapter, pulu from the hāpu‘u was used by wāhine to make pillow and mattress stuffing. Yet, within 50 years, its use had a dramatic shift from a traditional work product found in the kauhale to a commodity for export. From 1851 to 1884, several hundred thousand pounds of pulu were collected annually from the Kīlauea region on Hawai‘i Island and shipped to North America, with a peak in 1862 of over 738,000 lbs. 50-75 people worked at the “Pulu Factory” in the area now known as Hawai‘i Volcanoes National Park, between Makaopuhi and Nāpau Crater. After 1865, the exporting decreased until finally in the 1880’s superior stuffing materials replaced pulu (Ibid).

In 1840, the Kingdom Government promulgated its first Constitution, which, among other things, codified the ancient Hawaiian system of taxation:

There shall be two forms of taxation in the Hawaiian kingdom. The one a poll tax, to be paid in money, the other a land tax, to be paid in Swine; or these shall be the standard of taxation, though in failure of these articles, other property will be received. (Thurston, 1904, p. 12)

By including the requirement that Native Hawaiians pay the poll tax in money, the Constitution articulated a major systemic shift: Native Hawaiians traditionally paid taxes through goods or labor and shared in Makahiki, and the new requirement reflected the expectation that Native

Hawaiians would participate in commercial activities and in an increasingly capitalist economy. Early records indicate disparities and inequities ensued thereafter, for kāne and wāhine.

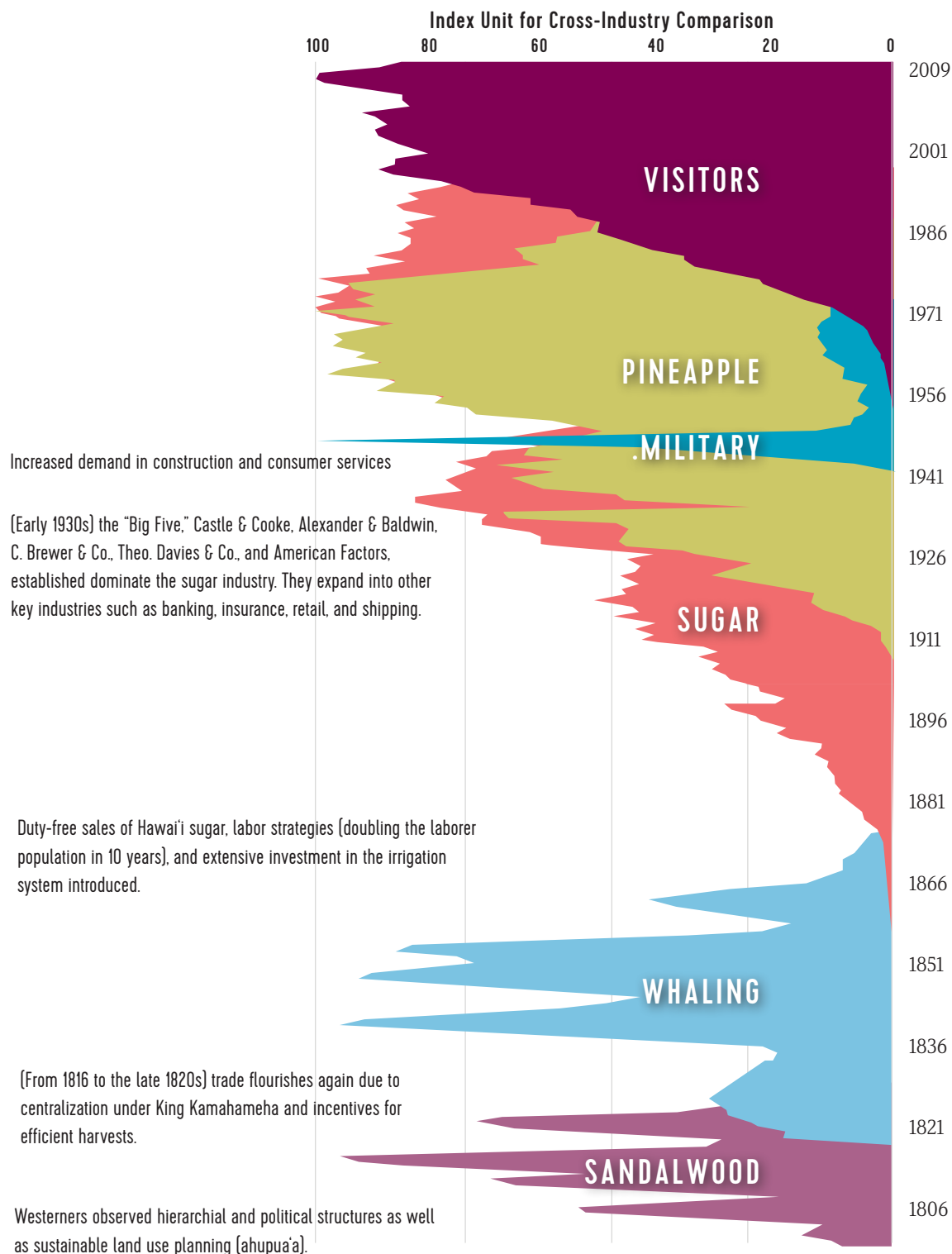
Concurrently, kānaka moved from the kauhale roles into urban cores like Honolulu, Lahaina, and Hilo near shipping ports, serving as the labor force within these emergent industries. Places of commerce, coupled with the population collapse due to infectious disease, caused massive demographic shifts to define an era of mo‘ohiia (entanglement) across every island (see Physical Health).

Further, land privatization in the mid-nineteenth century was one of the greatest catalysts of change to economics in Hawai‘i (Silva, 2004; Kameeleihiwa, 1992; Osorio 2002). Traditionally, land was held in common by all Native Hawaiians. Although the ali‘i controlled the use of resources and division of lands, they did not own land. However, beginning in 1848, the passage of the Māhele Acts allowed Native Hawaiians and eventually foreigners to acquire fee simple title to land. There was hope that the privatization of land would encourage commercial activity and industry for economic boom. Native Hawaiian historian Lilikalā Kame‘eleihiwa (1992) noted that this land privatization had direct connections to the loss of Native Hawaiian control of lands and resources, and resulted in the growing influence of foreigners in Hawaiian government structures (see Leadership and Civic Engagement chapter). It should be noted that non-Hawaiian men played pivotal roles in the economic shifts.

In the midst of this economic shift, ali‘i wāhine like Princess Pauahi, Queen Emma and Queen Lili‘uokalani provide examples of extraordinary, unprecedented acts when they bequeathed their lands in perpetuity to Native Hawaiians. Pauahi’s will established the Kamehameha Schools, for the education of Native Hawaiian youth, and Lili‘uokalani provided for Lili‘uokalani Trust, which works for the betterment of destitute and orphan Native Hawaiian children.

Despite a series of historical difficulties and profound transformations within Hawaiian society, Native Hawaiians have continued to actively seek economic stability as a means of providing a better quality of life for their families and communities. Ongoing cultural

Figure 5.1: A Timeline of Western Economic Drivers in Hawai'i by Industry



Note: Graphical timelines and data adapted from previously public report.
Source: La Croix, 2001 & Economic Development Administration, 2014, p. 6, with UHERO Charts.

resurgence has supported these efforts by strengthening Native Hawaiian practices and beliefs of sustainability and well-being. Community-based organizations are actively revitalizing these forms of trade and practice, with many notable contemporary wāhine leaders overseeing operations and executive oversight to their growth and success in the 21st century.

Hawai‘i’s Cost of Living Today

The cost of living in many countries is more than most women can afford. For single mothers, this issue is exponentially worse. It has been estimated that nationally, 45.5% of Asian/Pacific Islander births were to single mothers (Bonnie et. al, 2015). Research indicates that single parenting can also negatively impact the emotional well-being of the mother and child by increasing stress on the mother as the provider for her family, sometimes working multiple jobs (Ibid). Many of the issues that arise can be mitigated if women continue to have access to postsecondary education, funding for that education and are encouraged by their support network to pursue advanced degrees. That continued education can lead to improved housing and economic outcomes, but it does not happen automatically for every woman with an advanced degree. We must advocate for equal and equitable earnings in the workforce.

For example, Honolulu is the nation’s priciest city for groceries—and are 55.4% more expensive than the national average (Luthi, 2018). The city of Hilo is 52% higher than the national average. These prices are higher than Kodiak, Alaska (50 percent), Manhattan (45 percent) and Juneau, Alaska (38 percent). According to data analyses (Ibid) Hilo and Honolulu are ranked second and third most expensive cities to live in for utilities: Hilo is 112.4% above the national average, Honolulu is 94.8% above the national average. Hilo also ranks highest in the nation for transportation costs, which are 45.8% above the national average. Finally, for comparable figures, Honolulu is the 4th most expensive city to live in for housing costs: 198.5% above the national average behind Manhattan, San Francisco, and Brooklyn (Ibid).

According to the U.S. Department of Health and Human Services standard, any child care that costs more than 7% of a family’s income is considered unaffordable. According to data, childcare costs \$8,280 for annual infant care (based on the averages of home and center-based day care). Now imagine a single Native Hawaiian mother whose income is \$46,002 per year. Her childcare costs for her infant are roughly 18% of her annual income.

Figure 5.2: Hawai‘i Cost of Living Statistics (2016)

- » Median family income: \$74,919
- » Full-time minimum wage salary: \$17,680
- » Annual rent: \$19,524
- » Annual health insurance costs: Up to 10% of income
- » Annual infant care costs: \$8,280 (average of home and center-based day care)
- » Infant care costs as a share of minimum-wage earnings: 46.8%
- » Infant care as a share of rent: 42.4%
- » Infant care costs as a share of median family income: 11.1%
- » Savings to typical families with an infant from capping child care expenditures at 10% of income: \$788
- » Share of (post–child care) median income freed up by capping infant care expenditures at 10% of income: 1.2%
- » Median child care worker salary: \$18,230
- » Infant care costs as a share of child care worker earnings: 45.4%
- » In-state tuition for 4-year public college: \$8,216
- » Infant care costs as a share of public college tuition: 100.8%
- » Increase in state’s economy from capping families’ child care expenditures at 10% of income: 0.3% (\$219.0 million)

(Source: Economic Policy Institute, 2016.)

The median family income of Native Hawaiians is \$74,919 (2016); therefore, infant care for one child at the same annual rate would be 11% of their costs. At this rate, it is estimated that families who are able to afford infant care costs are about 47.3% of the State. There are many other annual costs for families to consider when raising children in Hawai‘i: private school education tuition fees, rental housing costs, monthly expenditures like food, transportation, and necessities. These all add up to a high cost of living and economic stressors on the family as a whole.

POVERTY

The 2018 Poverty Guidelines for Hawai‘i have been updated by the U.S. Census Bureau. These are used to determine eligibility to certain federal and state programs. The poverty guidelines may be formally referenced as “the poverty guidelines updated periodically in the

Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).” (U.S. Government Publishing Office, 2018).

The following table displays data for income levels during a twelve-month period, and then is broken out by gender and age groups. This enables the reader to understand where poverty rates are highest among Native Hawaiian females and males, respectively. It simultaneously compares those numbers to the statewide rates for females and males in order to provide a better lens on poverty disparities.

According to this data, Native Hawaiian females have higher poverty rates than the statewide average from ages birth to 34. The highest poverty group for wāhine are between 25–34 (16.6%). This is the highest poverty rate for the state of any age group for the four groups analyzed: Native Hawaiian female, Native Hawaiian male, Statewide female, and Statewide male. However, it does show that Native Hawaiian females have a lower poverty rate than the statewide females from ages 35 and above. For both Native Hawaiian males and females, the lowest poverty rates are at age 15 and after 75 years and older. Interestingly, the lowest poverty rate for Statewide females are aged 5. At this same age, Native Hawaiian males aged 5 have the highest poverty rates among the four groups. As mākua, Native Hawaiian male and female poverty rates begun to equalize at 45–54 years of age.

This data illustrates that Native Hawaiian males from birth through age 11 have higher rates of poverty than Native Hawaiian females of the same age ranges. However, from 18–24 and 25–34, wāhine poverty rates exceed kāne. These rates are helpful to design programming and support services for both groups. It is important to note that the highest poverty rates in 2016, were among keiki kāne aged 5 at 29.3%; their lowest rates aged 65–74 (8.8%) but this kūpuna range must factor in many variables. Critical to draw attention to is the poverty rates of Hawaiian males and females under age 5, which are higher for Native Hawaiians than non-Hawaiians. Alarminglly, poverty rates among Hawaiian boys (28.8%) are nearly double their non-Hawaiian peers (14.9%). Non-Hawaiian females experience higher rates of poverty from birth to age 14 compared to their male peers. For serious consideration is the age of greatest disparity for poverty among non-Hawaiian girls aged 18-24 (25.7%), which is more than 10 percentage points higher their non-Hawaiian peers (14.3%).

Figure 5.3: 2018 Poverty Guidelines for Hawai‘i

PERSONS IN FAMILY/ HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add \$4,970 for each additional person.	
1	\$13,960
2	\$18,930
3	\$23,900
4	\$28,870
5	\$33,840
6	\$38,810
7	\$43,780
8	\$48,750

Source: U.S. Government Publishing Office, 2018.

Figure 5.4: Poverty Status in the Past 12 Months by Sex by Age: Five Year Estimates (2011–2015)

Population	Total Female = 72,039 Total NH Female = 23,889						Total Male = 70,711 Total NH Male = 21,531						
	Age Range	NH Females Total n	NH Females In Poverty n	NH Females %	Non- Hawaiian Females Total n	Non- Hawaiian Females In Poverty n	Non- Hawaiian Females %	NH Males Total n	NH Males In Poverty n	NH Males %	Non- Hawaiian Males Total n	Non- Hawaiian Males In Poverty n	Non- Hawaiian Males %
	Under 5	14161	2,710	19.1	23,035	3,638	15.8	12,018	3,457	28.8	26,487	3,944	14.9
	5	2621	602	23.0	4,243	859	20.2	2,689	787	29.3	4,930	826	16.8
	6–11	16994	3,565	21.0	23,567	4,655	19.8	13,752	3,541	25.7	28,713	4,608	16.0
	12–14	7608	1,008	13.2	12,722	1,774	13.9	6,285	1,315	20.9	15,263	2,023	13.3
	15	2744	585	21.3	3,874	630	16.3	2,242	444	19.8	4,903	894	18.2
	16–17	4711	856	18.2	9,314	1,164	12.5	4,449	920	20.6	9,457	1,326	14.0
	18–24	16543	3,609	21.8	28,472	7,330	25.7	13,557	2,506	18.5	40,950	5,851	14.3
	25–34	20992	3,955	18.8	60,674	9,522	15.7	19,257	2,824	14.7	76,587	6,220	8.1
	35–44	16896	2,589	15.3	58,833	6,725	11.4	15,001	1,474	9.8	66,758	4,871	7.3
	45–54	16292	2,061	12.7	66,154	6,241	9.4	14,543	1,806	12.4	67,605	5,859	8.7
	55–64	13221	1,344	10.2	68,422	7,708	11.3	12,141	1,536	12.7	66,730	7,414	11.1
	65–74	8157	587	7.2	49,098	4,031	8.2	6,633	586	8.8	47,332	2,739	5.8
	75 and over	5407	418	7.7	46,111	5,067	11	3,379	335	9.9	32,614	2,605	8.0

Source: U.S. Census Bureau (2016), B17001, Poverty Status in the Past 12 Months by Sex by Age 2011–2015, 5-year Estimates, Accessed on 10/31/2017

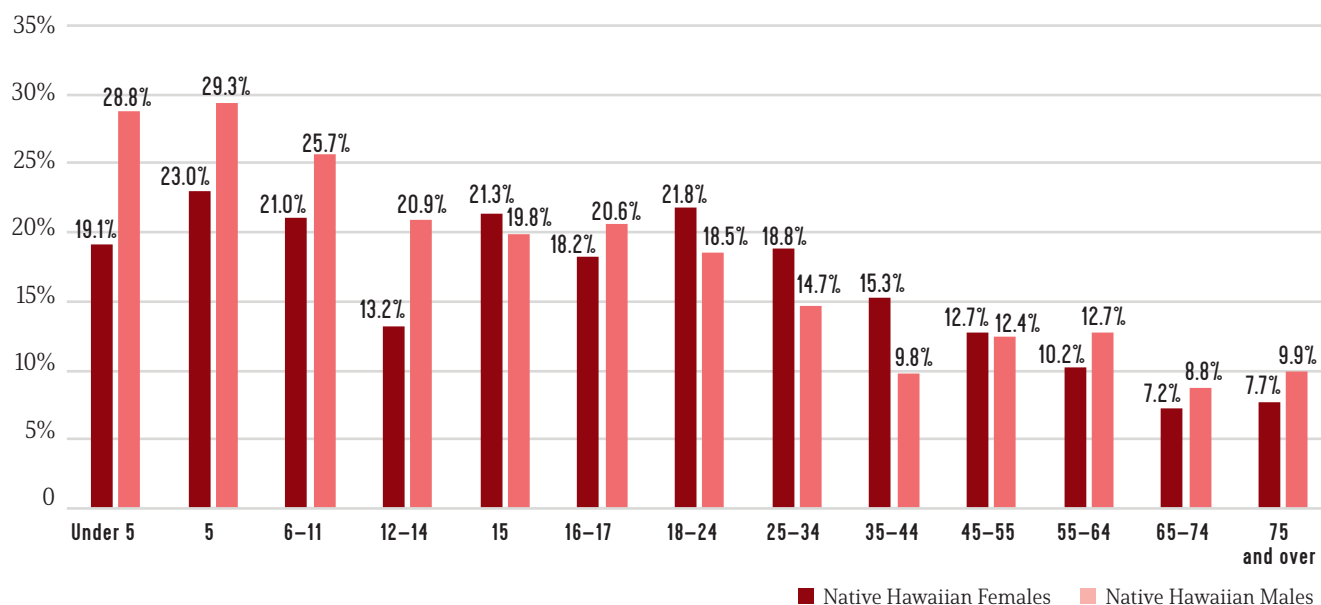
While comparing wāhine poverty rates to non-Hawaiian females, there are some important ranges to mention. Kaikamahine ages birth to age 11 have higher rates of poverty than non-Hawaiian females as do wāhine aged 25 through 54. Poverty highest rates among wāhine are highest at age 5 (23.0%) and lowest at from ages 65–74 (7.2%). Like kāne, this kūpuna age range must factor in many variables. The greatest disparity of poverty among females is at age 15, where Hawaiian females are 5 percentage points higher than non-Hawaiian females. This time during adolescence is an important time to make strides for the well-being of teen girls. For serious consideration is the age of greatest disparity for poverty

among Hawaiian women is aged 25–34 (18.8%), which is more than 10% higher non-Hawaiian males of the same age (8.1%). Further, wāhine poverty rates aged 35–44 are double (15.3%) than non-Hawaiian males (7.3%) during this range. It is important to consider these levels of comparison in policy planning.

HEALTH INSURANCE COVERAGE BY GENDER AND AGE

Health insurance relates to the economics of our well-being. Those not having health insurance face obstacles to their physical and economic health, which often

Figure 5.5: Poverty Rates (2016) Native Hawaiian Female vs. Native Hawaiian Male



Source: U.S. Census Bureau (2016), B17001, Poverty Status in the Past 12 Months by Sex by Age 2011–2015, 5-year Estimates, Accessed on 10/31/2017

become entwined. According to the Urban Institute, not having health insurance can mean five basic things for individuals and their families, regardless of ethnicity or gender or marital status:

1. Uninsured people receive less medical care and less timely care.
2. Uninsured people have worse health outcomes.
3. Lack of insurance is a fiscal burden for uninsured people and their families.
4. The benefits of expanding coverage outweigh the costs for added services.
5. Safety-net care from hospitals and clinics improves access to care but does not fully substitute for health insurance. (Bovbjerg & Hadley, 2007, p. 1–3)

According to the National Academies of Medicine, “Uninsured adults are less than half as likely as those with insurance to receive needed care for a serious medical condition” (Institute of Medicine, 2001, p. 2). These are not just any persons without health coverage, though.

Research indicates that uninsured pregnant women use fewer prenatal services and uninsured children are less likely than their uninsured counterparts to report having a regular source of care, to see medical providers, or to receive recommended treatment (Institute of Medicine, 2001; Bovbjerg & Hadley, 2007). Therefore, a lack of health insurance is an issue to be aware of for the well-being of wāhine, especially those who may be single mothers. In fact, more than 80% of uninsured children and adults under age 65 live in working families (Ibid). For families earning less than 200% of the federal poverty level, these expenses could easily amount to over 10% of their annual income. Family budgets are then challenged creating limited opportunity for options for their health compared to their level of poverty (Ibid).

Efforts to pass the the Patient Protection and Affordable Care Act (P.L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111–152) was a monumental effort by the government to improve health coverage status for affordable individual policies. “Because women are more likely to obtain coverage through individual policies and public programs, their insurance status tends to be less stable, with more opportunities for

Figure 5.6: Poverty Rates (2016) Native Hawaiian Female vs. Statewide Female

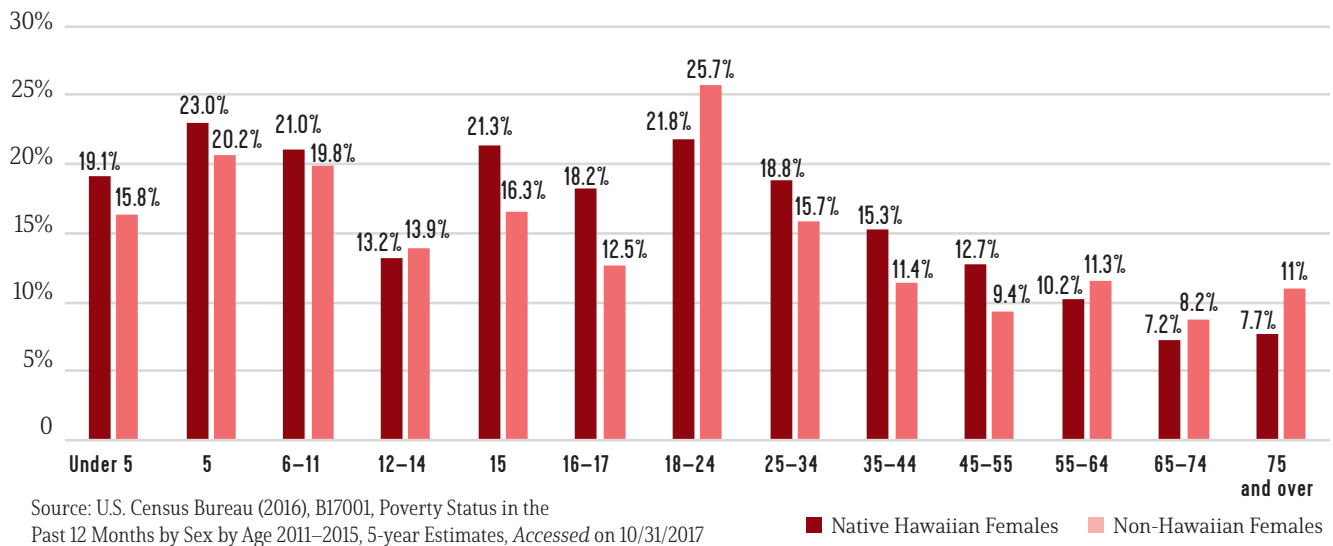
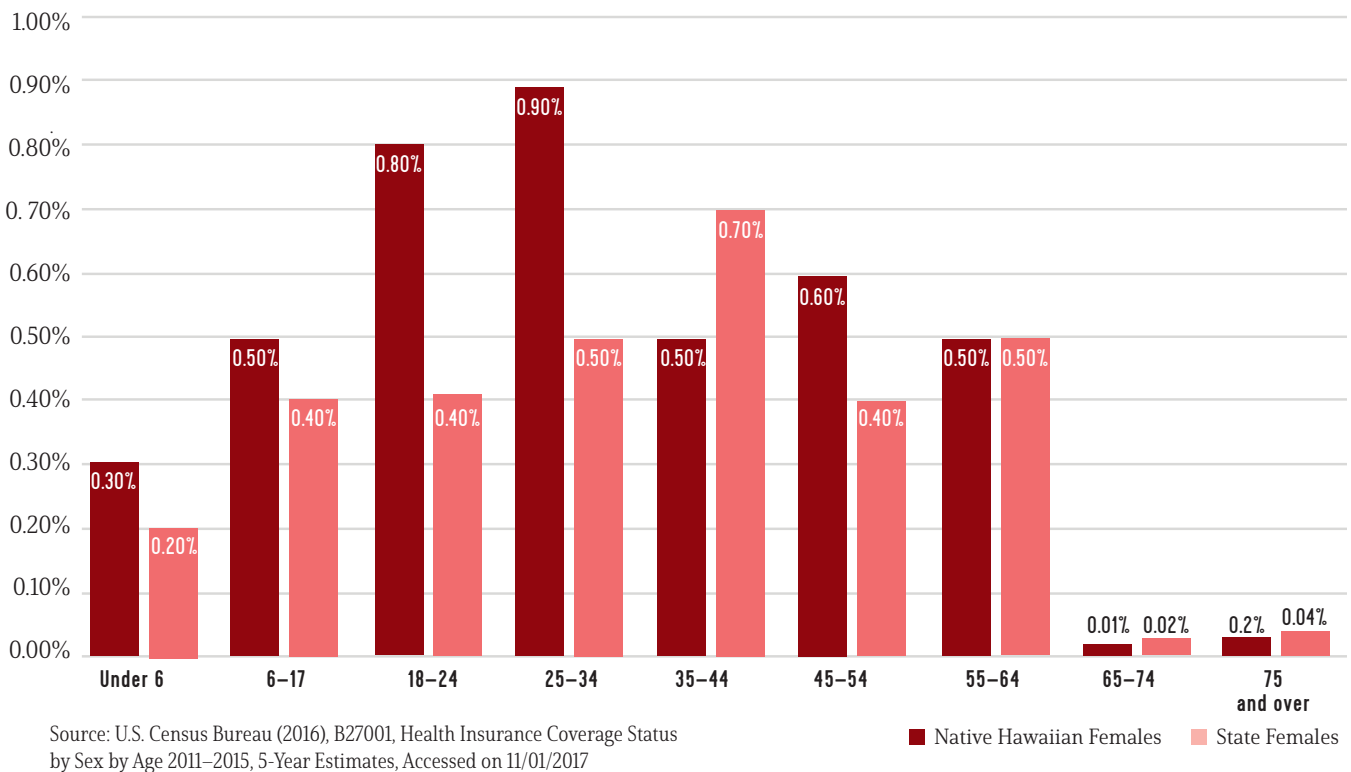


Figure 5.7: Native Hawaiian Females With No Health Insurance Coverage by Age Group (2011–2015)



gaps in coverage” (Institute of Medicine, 2001, p. 3). Thus, the creation of public policies that can enroll women, especially those in the gap periods, can serve as a policy mechanism to support women’s coverage.

U.S. Census Bureau data also gives us the ability to compare the lack of insurance coverage among four groups by their gender and age range during a five year aggregate: Native Hawaiian female, Native Hawaiian male, Statewide female, and Statewide male. Therefore, we get a very detailed set of information about where coverage gains can be made in the Native Hawaiian community. For example, the highest rates of no coverage at any age are among Native Hawaiian males aged 25–34 (2.0%). This coincides with the highest rates of no coverage among Native Hawaiian females as well, though more than half the rate of kāne. Such data indicates that outreach services could be geared toward wāhine and kāne simultaneously from ages 18–34, while also targeting those mākua who do not have health insurance, but do have keiki. Research indicates that, “Young adults aged 19–34 are uninsured more often than other age groups largely because they are ineligible for workplace health insurance—they are too new in their jobs or work in firms that do not provide coverage to employees” (Institute of Medicine, 2001, p. 2). Campaigns and coordination of coverage communication could be targeted toward these specifics and then tracked for another five-year period for trends. Efforts can also be made to educate employers of newly hired individuals aged 18–34 through local business forum. Few who do not qualify for Medicare remain vulnerable to being uninsured.

THE ROLE OF EDUCATION

Access to quality education can positively shape girls’ lives. Globally, millions of girls are denied the opportunity to an education, which limits their economic opportunity in the future. Over 60 million girls between the ages of six and fifteen are not in school, of which 16–17 million are expected to never attend primary school (World Bank Group, 2016; UNESCO, 2013). It has been shown that just one year of primary education can increase a woman’s future earning power from 10% to 20%, which increases as they further their education. Studies have shown

that for every additional year of school for 1,000 women there are two fewer maternal deaths, as educated women are more likely to access safe and clean health facilities (Population Reference Bureau, 2011). This pattern also continues into lower secondary education and beyond, effectively reducing positive health outcomes of women throughout their lives. Continued education of girls through post-secondary degrees, even in part, has the opportunity to reduce the burden of infant and child mortality, maternal mortality and morbidity, as well as increase economic self-sufficiency by narrowing the gender wage gap.

Compared to male young adults, females are more likely to graduate with their high school diplomas and pursue post-secondary education. Recent data suggests female enrollment in two- and four-year colleges surpass male participation in postsecondary education, resulting in women obtaining their bachelor’s and other higher degrees at higher rates than men (Bonnie et. al, 2015). National trends in education hold true also for wāhine, as they have higher educational attainment than kāne:

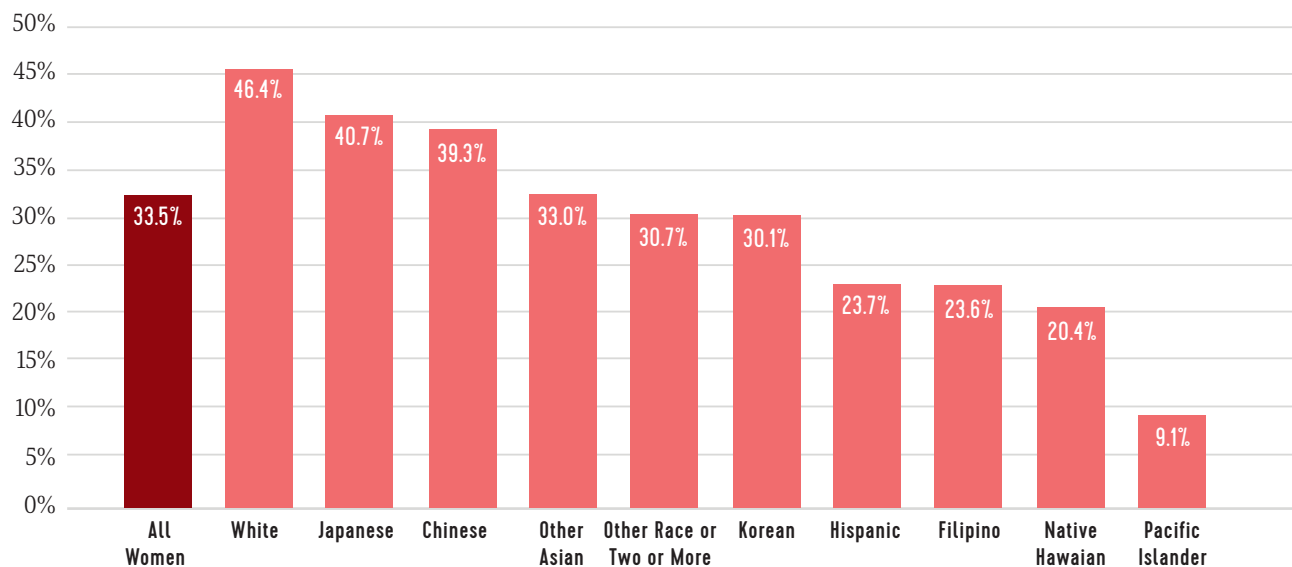
- » Native Hawaiian females aged 25 and older hold post-secondary degrees at a rate of 14.3% less than the statewide average.
- » NH females have a 4.7% higher percentage of holding a post-secondary degree than NH males.
- » Of note, females statewide hold more post-secondary degrees than their male counterparts.

Figure 5.8: Percent of Population with Post-Secondary Degrees (2016)

FEMALES		MALES	
Native Hawaiian	State of Hawai'i	Native Hawaiian	State of Hawai'i
19.2%	33.5%	14.5%	30.4%

Source: U.S. Census Bureau (2017), S0201, Selected Population Profile 2016, 1-Year Estimates Accessed on 10/31/2017

Figure 5.9: Percent of Women in Hawai'i with a Bachelor's Degree or Higher, by Race/Ethnicity (2015)



Note: Graphical data adapted from previously public report.

Source: Chart and data from Anderson and Williams-Baron, 2017, p. 21.

Since the Census Bureau data showcases statewide differences compared to Native Hawaiian female post-secondary degree rates, it is important to explore this data even further to reach an accurate picture of where educational gains can be made to influence a woman's economic well-being. The following table from Anderson and Williams-Baron (2017) indicates three year rates for Bachelor degrees by female ethnicity from 2013–2015. Compared to white women (46.4%), there is a 56% decrease of Native Hawaiian females holding the same degree (20.4%). Alarming, Pacific Islander women have a 80% decrease compared to their White counterparts (9.1%). By providing education from a young age, in safe spaces that foster the growth of young girls, we move towards healthy lives for future women and children; especially for those of whom are from underserved communities and disparate minority groups like Native Hawaiians and Pacific Islanders.

In the regional and sectoral study *Indigenous People and Poverty in Latin America An Empirical Analysis*, researchers found that indigenous women face multiple barriers when entering the labor market compared to men (1994). Childbearing, domestic housework, and cultural factors are likely to influence women from participating in the workforce. In the article *Career Aspirations of*

Women in the 20th Century, Domenico (2007) examines the literature around career choice and the barriers that influence women and their decision to participate in the workforce. Some of the perceived barriers women often experience are lack of transportation, occupational skills, and gender discrimination. In order to manage the many responsibilities placed on women they often turn to employment opportunities that offer flexible schedules and relatively good pay. The issue that arises is women are less likely to fulfill their employment potential and capabilities.

EMPLOYMENT AND INDUSTRIES

Native Hawaiian females make up 19.4 % of the total working female population of Hawai'i. Therefore, any Native Hawaiian female occupational representation above 19.4% can be considered over represented, while any occupational representation below 19.4% can be considered underrepresented. On the table of Native Hawaiian Female Representation, any occupational grouping above 'Health Technologists and Technicians' can be considered over represented, while any occupational grouping below 'Management Occupations'

can be considered underrepresented. Therefore, Native Hawaiian women are underrepresented in the following fields (2011–2015):

- » Life, physical and social sciences—11.8%
- » Arts, design, entertainment, sports and media—12.3%
- » Legal—12.8%
- » Health diagnosing and treating—11.3%
- » Production—11.4%
- » Farming, fishing, and forestry—15.8%
- » Computer and mathematical occupations—9.1%

EARNINGS AND WAGE GAPS

Around the world for decades, the wage gap between men and women has constantly been researched. The *Association of Collegiate Alumnae* is a non-profit organization that focuses on women's rights. A report was released in 2015 which compared white male and female wages. Their research indicated that white women are paid 80 cent per dollar a white man is paid. While this information is alarming, the American Association of University Women (AAUW) (2015) looked into Native women and discovered the wage findings were even lower for other women of color compared to employed caucasian females. Their findings demonstrate that American Indian and Alaska Native women were paid 58 cents per dollar, while Native Hawaiian and Pacific Islander women were paid 60 cents per dollar. Such research through research that women are still faced with wage gaps.

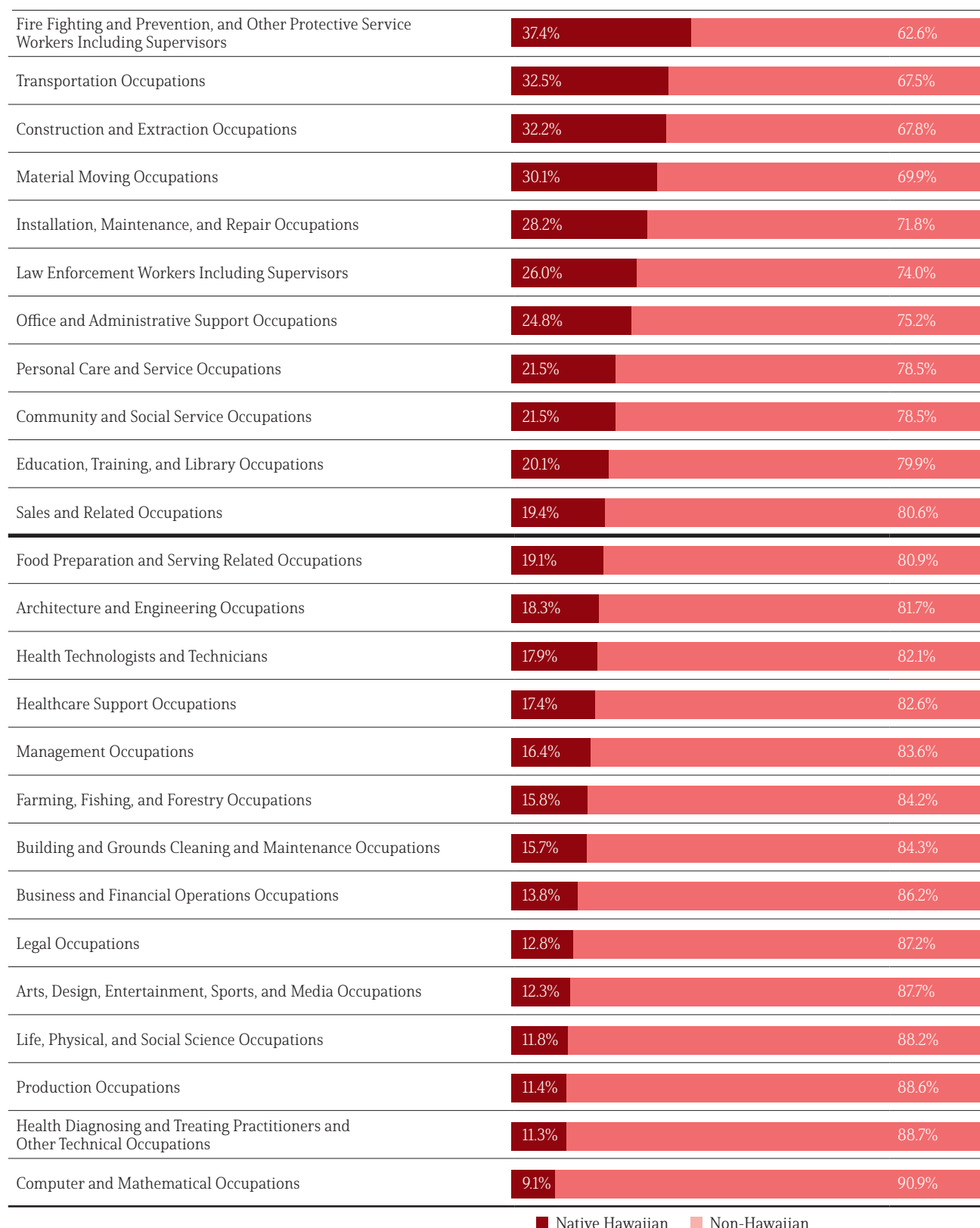
Institute for Women's Policy Research and Women's Fund of Hawai'i created an important report on the "The Status of Women in Hawai'i" (2017). Their analyses looked at disaggregated ratios for median incomes by gender and by race/ethnicity. Their data utilized three year aggregates (2013–2015) of the American Community Survey and we support their research here with our added interpretation: In Hawai'i, median annual pay for a woman who holds a full-time, year-round job is

\$40,434 while median annual pay for a man who holds a full-time, year-round job is \$48,074. This means that women in Hawai'i are paid 84 cents for every dollar paid to men, amounting to an annual wage gap of \$7,640. Filipinas and Native Hawaiian women have the lowest earnings (\$33,000 and \$37,000) (Anderson and Williams-Baron, 2017, p. 11–13). This indicates that Native Hawaiian women are paid 71 cents for every dollar men in Hawai'i get paid and 82 cents on the dollar that Native Hawaiian men get paid. Whereas, the lowest earnings of females, Filipina earn 63 cents for every dollar men in Hawai'i get paid and 87 cents on the dollar that Filipino men get paid.

When looking at one year estimates from 2016, we see slightly differing numbers when comparing Native Hawaiian Females to State Females and Native Hawaiian Males to State Males. This is to be expected when using different years between reports. Our analyses offer both mean and median earning rates by gender:

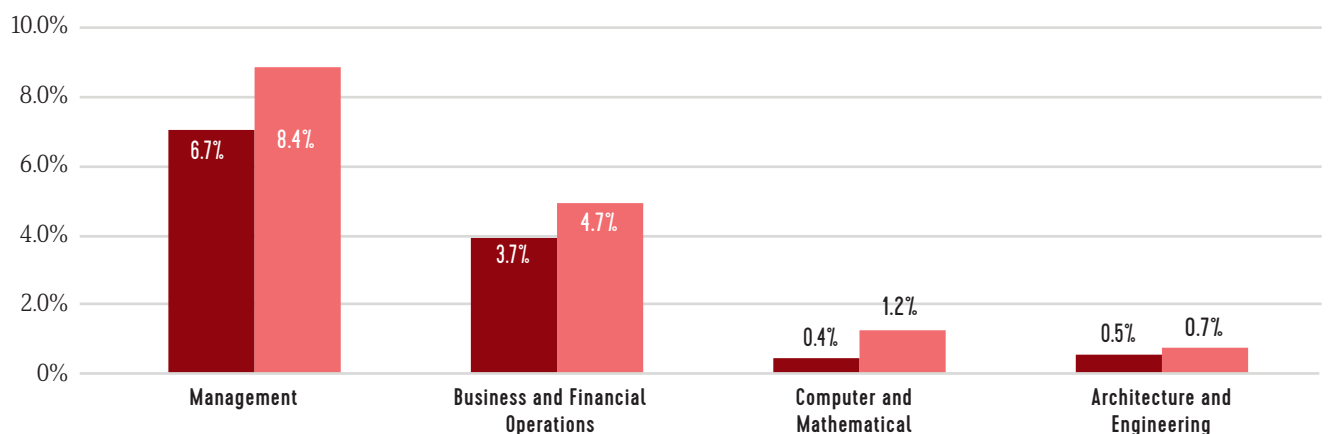
Both Native Hawaiian women and men make less than the Statewide mean and median annual earnings. Native Hawaiian females make on average \$5,967 less annually than that of the overall female Statewide population, with an annual median earning of \$4,027 less than the Statewide average. Native Hawaiian females make on average \$11,393 less annually than that of the Native Hawaiian male population, with annual median earnings of \$9,773 less than Native Hawaiian males. Figures are further exacerbated when comparing Native Hawaiian females and State of Hawai'i Males, where full time, year-round working wāhine mean earnings are more than \$19,000 less.

Among the industries of employment there is data that provides annual wage estimates for programmatic planning of interventions. For example, food preparation and serving related occupations average just over \$30,000 per year, and Native Hawaiian females make-up 1 in 4 of these employees. Similarly, Native Hawaiian women in healthcare support occupations earn \$34,170 per year, and also make up nearly 25% of this workforce in Hawai'i.

Figure 5.10: Native Hawaiian Female Occupational Representation and Comparison by Type (2011–2016)

Source: U.S. Census Bureau (2017), C24010, Sex by Occupation for Civilian Employed Population 16 Years and Over 2011–2015, 5-Year Estimates, Accessed on 4/19/2018

Figure 5.11: Occupational Representation Native Hawaiian Females and State of Hawai'i Females (2016)



Source: U.S. Census Bureau (2017), C24010, Sex by Occupation for Civilian Employed Population 16 Years and Over 2016, 5-Year Estimates, Accessed on 10/31/2017

■ Native Hawaiian Females ■ State of Hawai'i Females

When looking at the share of wāhine in managerial or professional occupations, a little over 1/3 of Native Hawaiian women absorb that level, 6% lower than the average for women in the state, but nearly 10% higher than Filipina women, who represent the lower share of managerial or professional employment. Whereas White and Japanese women's share of managerial and professional occupations in Hawai'i each share nearly 50% of the workforce; thereby increasing the statewide average proportionately for females.

Both Native Hawaiian females and males have a lower percentage of occupational representation on all four occupational categories than the Statewide averages. As represented in these two charts, there are distinct similarities and differences in occupation representation in the State when analyzing by race and gender. Less than half of wāhine are represented in computer and mathematical positions (0.4%) compared to kāne (1.1%) both who are out represented by Statewide females (1.2%). Nearly one third of wāhine (0.5%) and half of Statewide females (0.7%) are represented in architectural and engineering positions compared to kāne (1.4%). However, kāne and wāhine are equally represented in management positions (6.7%), though this is about 2.5% less than Statewide females in the same positions (8.4%).

Interventions & Recommendations

Education at all levels can have a positive impact on wahine well-being. Postsecondary education has been linked to delayed family transitional roles, such as marriage and parenting. These transitional roles occur in three ways: cohabitation, marriage, or parenting (Bonnie et. al, 2015). In most cases, women are marrying at later ages, having their children at later stages, and often living with their parents as single mothers largely in part to their lower educational attainment and socioeconomic status. The priorities of women across the nation and globe are changing, as women aspire to become more educated and involved in the professional workforce. Historical data has shown that women were transitioning into familial roles at much earlier stages of adulthood, then is currently seen today. Where the median age of marriage 30 years ago was 22, it is now 27 years old.

An increase in women's education can vastly improve market productivity and income growth for all. Women who are educated have an impact on homes by increasing family health, child survival, and investment in children.

Figure 5.12: Mean and Median Earnings Comparisons, by Race/Ethnicity and by Gender (2016)

Indicator	FEMALES				MALES				NATIVE HAWAIIAN FEMALES & STATE MALES			
	NH Females	State Females	Difference (\$)	Difference (%)	NH Males	State Males	Difference (\$)	Difference (%)	NH Females	State Males	Difference (\$)	Difference (%)
Mean Earnings	\$44,620	\$50,587	(\$5,967)	88%	\$56,013	\$63,634	(\$7,621)	88%	\$44,620	\$63,634	(\$19,014)	70%
Median Earnings	\$37,197	\$41,224	(\$4,027)	90%	\$46,970	\$49,373	(\$2,403)	95%	\$37,197	\$49,373	(\$12,176)	75%

Note: Full time, year-round workers.

Source: U.S. Census Bureau (2017), S0201, Selected Population Profile 2016, 1-Year Estimates, Accessed on 10/31/2017.

In addition, wāhine ages 25–34 should be offered support services to help them manage their income, savings, and assets during this decade of their life. Looking at these themes in combination, there is a clear need to addressing the needs of kāne, wāhine, and their 'ohana more holistically.

In regard to the workforce, despite women's advanced education and skills development, and their increased participation in the workforce, the gender wage gap persists. For Native Hawaiian women in their industries, economic inequities are significantly pronounced and have compounded impacts. If we consider not only the number of women represented, but the wages which they incur, this data can illustrate opportunities

for increasing annual wages for wāhine. For example, the majority of Native Hawaiian women are in office and administrative support positions with an average annual wage of \$38,620. Better wages for wāhine who are administrative professionals would make a substantial impact to their economic well-being. According to the Bureau of Labor Statistics, the mean annual wage for these positions in \$54,520; about \$3,000 more than the annual average in Hawai'i. In fact, in the District of Columbia, the annual mean wage for these same positions is \$72,330 per year; more than \$20,000 more per annum than Hawai'i (Occupational Employment and Wages, May 2016).

Even when women hold the skills and education to fulfill the job descriptions they are paid differently. One way to address this income gap and pay, is for more women to become owner of businesses and firms. Another way is to increase the number of women in managerial, executive, or professional fields, which have higher salary grades than other positions. Further, these types of positions are usually credited with leadership development tracks and corresponding benefits. Wāhine in managerial, executive and professional forum have an ability to be mentors and peer support for other wāhine following in their footsteps. According to the Hawai'i State Commission on the Status of Women (2014), 11.3% of businesses owned by women in Hawai'i, are owned by Native Hawaiian females. Business ownership alone can have substantial impact on a woman's decision-making and innovative power.

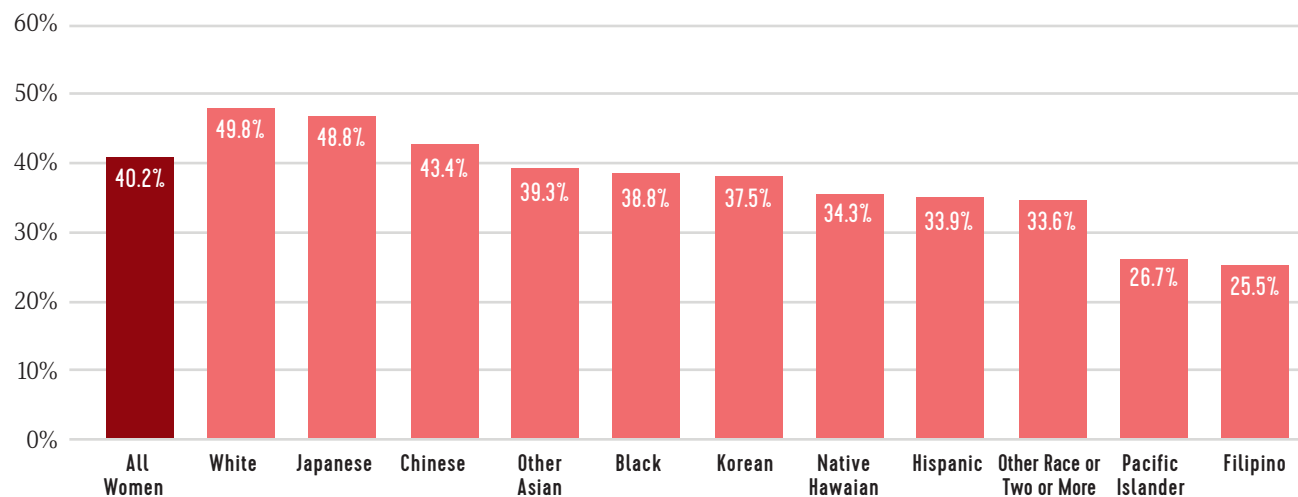
Figure 5.13: Difference in Mean Earnings, by Race/Ethnicity and by Gender (2016)

Indicator	NH Female/ State Female	NH Females/ NH Males
Difference in Mean Earnings	\$5,967	\$11,393
Difference in Median Earnings	\$4,027	\$9,773

Note: Full time, year-round workers.

Source: U.S. Census Bureau (2017), S0201, Selected Population Profile 2016, 1-Year Estimates, Accessed on 10/31/2017.

Figure 5.14: Share of Employed Women in Managerial or Professional Occupations in Hawai'i, by Race/Ethnicity (2015)



Note: Graphical data adapted from previously public report.
Source: Chart and data from Anderson and Williams-Baron, 2017, p. 14.

Figure 5.15: STEM, Management & Business Occupations Representation Comparisons by Gender (2016)

Populations 16 years and older	Total Female State = 328,501 Total NH Female = 60,679				Total Male State = 357,986 NH Male = 64,225			
	Females				Males			
	Native Hawaiian		Statewide		Native Hawaiian		Statewide	
Management	4,057	6.7%	27,533	8.4%	4,321	6.7%	36,451	10.2%
Business and Financial Operations	2,236	3.7%	15,557	4.7%	1,255	2.0%	11,458	3.2%
Computer and Mathematical	247	0.4%	3,795	1.2%	711	1.1%	9,018	2.5%
Architecture and Engineering	330	0.5%	2,439	0.7%	870	1.4%	10,444	2.9%

Source: U.S. Census Bureau (2017), C24010, Sex by Occupation for Civilian Employed Population 16 Years and Over 2016, 5-Year Estimates, Accessed on 10/31/2017

According to The Institute for Women's Policy Research and Women's Fund of Hawai'i (Anderson and Williams-Baron, 2017), there are several policies initiatives can support the economic health of wāhine. They are shared within this report in order to support national efforts which are already underway and have been previously published. We encourage readers to review their full report:

- » Closing the gender wage gap
- » Fully enforce legislation to address fair labor standards and laws regarding pay transparency that allow women to determine if they are being underpaid relative to comparable men without fear of retaliation;
- » Bar employers from requiring potential employees to submit previous salary history (which can perpetuate wage inequality) [Author's note: at the time of this report publication, this bill was successfully moving through the legislature];
- » Hold employers accountable for their hiring, compensation, and promotion practices to identify gender and racial disparities.
- » Ensure that the minimum wage is adequate to cover the exceptionally high cost of living in Hawai'i, state legislators should continually compare the state's minimum wage with a living-wage index and increase as necessary.
- » Philanthropists and state and local government should make educational opportunities for Pacific Islander, Native Hawaiian, Filipino, and Hispanic women in Hawai'i a particular focus of investment in scholarship and grant programs (p. 31).
- » Hawai'i can ensure that state and local government contracts are accessible to women-owned and minority-women-owned businesses.
- » Women's entrepreneurship can also be encouraged through public and private sector investments in loan and entrepreneurship programs, and through technical assistance to women entrepreneurs to help them to identify sound business and financing opportunities to start or grow their business.

- » Hawai'i's civil protection orders could be improved to better support survivors of violence (Recommendations from Anderson and Williams-Baron, 2017, p. 31)

The Hawai'i State Commission on the Status of Women (HSCSW) was created by Executive Order by Governor John Burns on May 15, 1964. Its function is to be a central clearinghouse of resources, services and advocacy for women and girls in Hawai'i. By doing so, the Commission can serve as an informational resource for Hawai'i's women and girls on policy issues. According to the Hawai'i State Commission on the Status of Women (2014), there are several state policies that can be addresses to support the economic health of wāhine. They are shared within this report in order to support local efforts which are already underway:

- » Paid Family Leave policies that allow women to take leave from work while ensuring job security and a partial income. "This would promote workforce participation and morale and reduce stress for many working-class citizens. Hawai'i's Family Leave Law only applies to those businesses with 100 or more employees and allows for 4 weeks of unpaid leave. For employees at businesses of less than 100 employees, the decision of whether one receives unpaid maternity leave, paternity leave, or leave to take care of an aging and ill parent or spouse is completely dependent on the employer" (Hawai'i State Commission on the Status of Women, 2017, p. 8–9).
- » The Commission recommends passing an Equal Pay revision to safeguard pay equity and economic justice for Hawai'i's working families (Hawai'i State Commission on the Status of Women, 2017, p. 9).
- » The Commission recommends raising the minimum wage to close the gender wage gap. Closing the wage gap has been identified as a means to lift a large percentage of families out of poverty. Further, the retitling should be conducive with principles of "living wage" that recognize the high cost of living in Hawai'i (Hawai'i State Commission on the Status of Women, 2017, p. 9).

Figure 5.16: Top 5 Native Hawaiian Female Occupational Groupings with Annual Average Wages, Ranked by Number of Women (2006–2010)

Occupational Groupings	Wage (\$)	Native Hawaiian Women (N)
Office and administrative support occupations	\$38,620	15,642
Sales and related occupations	\$35,820	8,673
Education, training, and library occupations	\$51,710	6,032
Food preparation and serving related occupations	\$30,750	4,729
Healthcare support occupations	\$34,170	2,087

Source: 5 year, 2006–2010 ACS Selected Population Tables, C24010 and May 2016 State Occupational Employment and Wage Estimates, Hawai'i

Figure 5.17: Businesses Owned by Women in Hawai'i (2014)

	N	% of Women Owned
Total	37,343	31.0%
White women	18,669	50.0%
Native Hawaiian and Other Pacific Islander women	4,234	11.3%
Native Hawaiian women	4,013	10.7%
Other Pacific Islander women	123	0.0%

Note: Data adapted from previously public report.

Source: Chart and data from Anderson and Williams-Baron, 2017, p. 14.

Additional recommendations include:

- » Support voluntary and gradual retirement for women and provide incentives for women to save for retirement. Retirement accounts that are accessible and available for all women. The account could have a federal matching component for workers that meet a defined set of eligibility criteria.
- » Improved and updated research and data regarding women's employment from age 30–59. Women are delaying child rearing to pursue educational and career opportunities. Policies and research must include these new social and cultural constructs.
- » Enable equitable entry into the labor force and provide equal earning rates for all.
- » Expand the Kupuna Caregivers Act 2017 and increase the coverage rates and eligibility
- » Create campaigns and coordination of health insurance coverage communication targeted toward employers of newly hired individuals aged 18–34, targeting pregnant women and employees with children.
- » According to the National Academies of Sciences, Engineering, and Medicine (2016), “Working conditions for women may also play a role in health. Several key aspects of the organization of work are related to job stress and lower job satisfaction, such as heavy workloads, little control over work, lower levels of substantive complexity, and little work-related social support” (p. 40). Therefore, this report recommends looking at workplace associated stress factors among wāhine and the fields in which they are overrepresented. This type of research could help us draw critical connections between workplace wellness and the daily burden placed on working wāhine.
- » Work-family conflict, in turn, is associated with overall physical health and, in particular, with hypertension and high blood pressure (Frone et al., 1996)” (in National Academies of Sciences, Engineering, and Medicine, 2016, p. 41). At this time, local data that connects these indicators for socioeconomic and behavioral health are not available, but a collaborative initiative to investigate these compound conditions in Hawai'i would be a wealth of information for intervention and organizational policy planning.


Mo 'Ono Hawai'i

For Ku'ulei Hanohano and Toni Matsuda, co-owners of Mo 'Ono Hawai'i, what started out as a “very part-time” way to make cash has turned into a successful and satisfying business.

They started Mo 'Ono in 2012 while at UH Maui Outreach College—both earning their degrees in Interdisciplinary Studies—making and delivering acai bowls to friends and family in the evenings, two to three times a week. “That’s how it started: we’d stop at maybe 10 different houses a night. It was manageable,” Hanohano remembers. “We kept doing it, and started to realize there was a demand for it. We were making and delivering 100 acai bowls a night. We found ourselves delivering to complete strangers, and at that point we had to assess: How can we make it easier to reach us and purchase our product, while making it more consistent?”

Their solution was a food truck. They worked with family members to build their first trailer, a 5' by 10' trailer, which opened up more opportunities for Mo 'Ono. “Because we had a structure, we were able to do festivals, fairs, pop-ups, and school projects, and were set up on weekends at Kahului Harbor.”

They were also able to grow their business through savvy use of social media. “Our business would not be what it is without social media,” Hanohano says. “Other food truck vendors would be like, ‘How do you always have a line?’ And we would teach them how to use Facebook, Instagram. More than just our own truck, we like sharing other’s endeavors—and in turn, other folks share our story. For example, Olamau Farms approached us about carrying their poi as an ingredient in our bowls, and we post and tag them, and they got their own following to the community.”



Despite a proven product and consumer response, there have been challenges along the way, especially with the more formal aspects of the business. Hanohano and Matsuda looked for a loan to expand, but “When I went in to the bank, no one took me seriously,” Hanohano notes. “We were 23, 24 years old. I had to do a lot of research on my own. Besides it being hard when you’re young, it’s even harder when you’re a woman—running and owning a business.

“Both Toni and I never had taken a business class,” Hanohano says. “I wish there could even be a preliminary class, on how to register your business, register your name. There are many things that are not common knowledge, and all that is a hang up for many people. I feel there would be way more businesses if there was even a one-, two-hour workshop on it.

“Luckily for us, it happened slowly, over the years,” she reflects. “At those different transition parts—from our homes, to the first trailer, and now to our newer, larger trailer—we were able to reflect, and note: ‘I think there’s something we need to pay attention to here.’ We realized each part was going to be the next level, a new chapter as we grew.”

Currently, they are both running the food truck full time. “It may sound strange, but we are passionate about what we do. It has brought us joy to know people enjoy our product—it’s very satisfying,” Hanohano says. “I tell people all the time, ‘If you have an idea, start small. Scale it down really simple to a small investment of time, energy, money. And go from there.’ We don’t have any examples in our families or friends who have small businesses, so it was scary for us, but we started small.”



The success of Mo ‘Ono is also a celebration of their relationship. High school sweethearts, Hanohano and Matsuda feel “our business is what it is because our relationship. I’ve seen a lot of businesses fail because of conflict,” Hanohano says. “And for us, each new chapter has been scary, but because we have each other we were able to roll with it. We will reach new levels, and we are able to do so because we have a solid foundation.”

Her sentiment brings added depth to their slogan: “Satisfy your ‘ono. Nourish your na’au.”

Leadership and Civic Engagement CHAPTER 6

Kū ka lau lama.

Many torches stand.

There are many lighted bonfires, a signal of joy and victory. (‘Ōlelo No‘eau, #1889)



Kānaka ‘ōiwi today are experiencing a revival of Hawaiian ways of knowing through the skilled observations of the lunar shifts, ‘aimalama, led by wāhine who promote the practice of kilo, environmental observation and resource management:

“[By] bearing witness to the empowerment we can collectively have by engaging with each other and with our environment. Let us not wait for others to provide solutions that solve our problems. Let us uplift one another, bear witness and recognize the changes, and rely upon our ancestor’s survival methodologies to adapt to those changes that are happening now to assure that our peoples and our practices will continue to exist in the future” (Nu’uhiwa, Lilly, Nobrega-Olivera, & Huihui, 2016, p. 4).

Similarly, the well-being of wāhine is revived with each and every leader whose kuleana protects health equity and perpetuates cultural heritage for kānaka to thrive.

Traditional understandings of wāhine leadership

AKUA

Malo writes (1903), “In the genealogy called Kumulipo it is said that the first human being was a woman named Lailai and that her ancestors and parents were of the night (he po wale no) that she was the progenitor of the (Hawaiian) race” (p. 4). It was said that “in her hair she wore the stars” and lived at Papahānaumoku in the Northwest Hawaiian Islands (Kaupiikauinamoku, 1956) and in the land of Lua (Johnson, 1981). Of significance to her role in the leadership of kānaka maoli in kēia au, the period of living humans in the Kumulipo, La’ila’i becomes the mother of gods and people, including Kanaloa.

Probably the most widely known goddess or demigoddess of Polynesia is Hina, who is frequently connected with the moon, or mahina and the celestial bodies who possess feminine conditions. “Hina displays many powers comparable to those of Kū, with whom she collaborated in many ventures, including the gods’ ‘first’ landing in Hawai‘i” (Kanahele, 1986, p. 95). Pukui & Elbert (1964) list four well-known Hina deities in Hawai‘i:

1. Wife of Akalana and mother of Maui
2. Mother of Kamapua‘a by Kahiki‘ula
3. A wife of Wakea and the mother of the island of Moloka‘i
4. A goddess associated with Kū.

When gathering medicine with their left hands, kānaka pray to Hina for success of these medicines to work successfully and restore health. Not only is the left side symbolic to Hina, but the moon under which these medicines are gathered and prepared is also to honor the cosmic factors which ensure recovery.

Hauwahine (literally, female ruler) is another of the beneficent mo‘o goddesses listed by Pukui & Elbert (1964). She lived at Kawainui and Ka‘elepulu ponds in Kailua, O‘ahu following Haumea; as ruler she brought an abundance of fish, punished the pond owners if they oppressed the poor, and sought to protect the area against greed. Hauwahine slept on ‘uki‘uki (a type of lily) leaves which yellowed them, warding off sickness in the sacred place she oversaw (Pukui & Elbert, 1964).

KĀHUNA, KĀLAIMOKU, AND KĀULA

Malo (1903) stated that the kahuna had authority over state religion and the kālaimoku (high official, counselor) over government administration. The two held important roles in governmental leadership and had the power to dispose of an unfit ali‘i. This was the case with Haka, who was said to be stingy and did not treat the people well. The kākūna chose Mā‘ilikūkahiki to rule instead as Mō‘i of O‘ahu (Kamakau, 1991b).

Kākūna were experts in their profession, male or female (Pukui & Elbert, 1986). The term is further qualified by the area of expertise such as a kahuna kākū wa‘a, an expert in canoe design and construction—or a kahuna

ho‘oulu lāhui, a priest who increased the population by praying for pregnancy, or a kahuna ho‘oulu ‘ai who was an agricultural expert (Pukui & Elbert, 1986).

A kākūla, or prophet could also give counsel to the ali‘i. Pine was a kākūla wahine who along with Holo‘ae, advised Kamehameha to not go into battle with Kiwala‘ō in the battle of Mōkū‘ohai (Kamakau, 1996). Other kākūla wahine were Nua, Nuakea, Kapauonuakea, and Lanikepua (Unknown, 1893), who possess qualities of leadership that can be inspirational today.

ALI‘I WĀHINE

The political sphere was well traversed by wāhine from ka wā kahiko. Ali‘i wāhine strived to make the best decisions for their people and throughout history have held influential roles in the running of the government, the management of natural resources, warfare, and the fight to preserve the independent status of the Hawaiian Kingdom. Ali‘i wāhine asserted their role around the world, which cost some their lives as they represented the needs and interests of the lāhui.

A major role of the ali‘i was to keep order by caring for the people ensuring the land was productive. Ali‘i were advised by their kākūna on religious and political matters and were supported by the other ali‘i, kākūaimoku, koa (warriors), and the maka‘āinana (general populace). The time of Kūkūaniloko, the first Mō‘i wahine (supreme female ruler) of O‘ahu, was said to have been a peaceful and prosperous time.

Ali‘i were expected to create bounty on their lands and if a famine occurred it was thought that the ali‘i did not properly tend to his religious responsibilities. In that capacity, ali‘i also acted as konohiki, or people who managed the natural resources of the land. Wāhine were also engaged with ‘āina (land) and kai (sea). They facilitated community projects such as the building and maintenance of an ‘auwai or loko i‘a. Kalanimanu‘ia, who became Mō‘i wahine after her mother, Kūkūaniloko, organized the building of Paiau, Opu, and Kapa‘akea fishponds and the lo‘i complex in Kaluaao, ‘Ewa, O‘ahu located near the present day Pearlridge Shopping Center (Kamakau, 1865). Later, during the constitutional monarchy, Emma Nakuina was a prominent kaukau ali‘i (lesser chief) who served her people in many capacities. She was an author and served as a Kingdom

water commissioner for fifteen years where she settled disputes over water rights in the district of Kona, O'ahu (Hopkins, 2012).

Ali'i wāhine were also political strategists that acquired mana through the two paths described by Kame'eleihiwa (1992) as the path of Lono—genealogical power—or Kū, warfare. An example of the path of Kū was Keakealaniwahine who acquired political power through gaining control of a luakini, a heiau usually controlled by kāne (Ii, 1963). According to Jensen and Jensen (2005), Keakealaniwahine was instructed in military strategy, political science, government administration and rituals usually reserved for male ali'i. She was “educated in the rituals and observances usually reserved for male ali'i of the highest status, genealogy, and mana” (Crabbe et al., 2017, p. 35). Keakealaniwahine was the second wāhine to independently rule Hawai'i Island in the 1600's as Ali'i Nui. I'i (1963) describes her unequalled rank of high chiefess:

As there was no other chiefess her equal, she was kept apart, with the chiefs who had the right to the prostrating kapu and away from places where people were numerous...Though a woman, Keakealaniwahine was permitted to enter the heiaus to give her offerings and sacrifices. However, she was not allowed to eat any of the offerings and gifts with the priests and the men. (p. 159)

Later, Keōpūolani represented the path of Lono through her high lineage and the birthing of akua children, Kauikeaouli and Liholiho, who went on to become the Mō'i of Hawai'i.

The position of Kuhina Nui, an advisor to the Mō'i, was almost exclusively held by wāhine and held great influence over political rule following Ka'ahumanu. The role of the Kuhina Nui was to carry out the will of the high chief (Kapelino, 2007) and share in the administration of the government while the Mō'i held absolute power. Ka'ahumanu stated that on his deathbed, Kamehameha I whispered in her ear that she should hold this position and rule alongside the new Mō'i, young Liholiho (Kamakau, 1996). During Ka'ahumanu's time as Kuhina Nui, the position acquired increased power over government rule (Kame'eleihiwa, 1999). Her father, Ke'eaumoku, had served as Kuhina Nui under Kamehameha I (Ibid), but her power went on to surpass her father's in this prominent position.

The Kuhina Nui is said to be akin to a prime minister or regent in other countries. With the Mō'i, the Kuhina Nui signed official documents and she conducted executive business affecting the monarchy as a special advisor. Later, the role of the Kuhina Nui expanded to receive and transfer government lands, and serve with exclusive veto power over the Mō'i. At her death, Ka'ahumanu was succeeded by her niece, Kīna'u. Kīna'u's daughter, Victoria Kamāmalu, was heir to Kuhina Nui, but as she was still young when her mother died, therefore Kekāuluohi served as Kuhina Nui under Kamehameha III (Ii, 1963). Kekāuluohi was also known as Ka'ahumanu III, and was the Kuhina Nui who signed the first Constitution of the Hawaiian Kingdom in 1840. Following Kekāuluohi as Kuhina Nui was Keoni Ana, the son of Kamehameha's advisor John Young. Victoria Kamāmalu finally rose to her kūlana became Kuhina Nui in 1857 under Kamehameha III. Among her notable work was establishing the Ka'ahumanu Society, due to her concern for elderly and ill kānaka, which included the creation of a hospital for smallpox in 1863, located in what present-day Honolulu (Fox, 2017). Victoria Kamāmalu died in 1866 and marked the end of the term of the last Kuhina Nui.

Ali'i wāhine also served as kia'āina (governor), who collected taxes and reported to the Kuhina Nui. Liliha, another relative of Ka'ahumanu, served as kia'āina of O'ahu, an office she inherited from her kāne, Boki (Kame'eleihiwa, 1999). Kakau'ōnohi, a granddaughter of Kamehameha I, also served as kia'āina over Kaua'i and Ni'ihau (Ibid).

HUI HAWAI'I ALOHA 'ĀINA

The late 1800s was a pivotal time in the political history of our lāhui. Wāhine continued to advocate for the best interest of their people, namely Queen Lili'uokalani and the women of the Hui Hawai'i Aloha 'Āina (Hawaiian Patriotic League). In 1887, under pressure and threat to his life by foreign businessmen, Kalākaua signed the 1887 document referred to as the “Bayonet Constitution” (Lili'uokalani, 1990). This constitution limited the King's power, by requiring the signature of a member of the cabinet in order for his acts to take effect (Article 41).

In January 1893, Lili'uokalani set to promulgate a new constitution (Lili'uokalani, 1990). The Queen was unable, due to the lack of support from her cabinet. She publicly announced her intent to not bring forth a new constitution and that any changes to the existing constitution would be done through means provided for in law. Compassionate rationale for this decision included the physical protection of her people at risk of loss of life and catastrophe, indicating her protective and nurturing nature as a leader.

At this time, a group composed of mostly foreign businessmen who called themselves the Citizens Committee of Safety, along with the help of U.S. Minister John L. Stevens and the U.S. Military attempted to overthrow the Queen. Stevens caused American troops from the U.S.S. Boston to land in Honolulu to “protect American life and property” (Smith, 1895). In order to avoid bloodshed, the Queen yielded her authority to the U.S. Government until such time that it would be returned to her (Silva, 2004). U.S. President Grover Cleveland refused annexation attempts with the Provisional Government and launched an investigation led by James Blount, which concluded that the overthrow could not have happened without help from the U.S. military.

The overthrow of Lili'uokalani and imposition of the Republic of Hawaii was contrary to the will of the Native Hawaiians. Kānaka staged mass protest rallies and formed two gender-designated groups to protest the overthrow and prevent annexation. At this time the Hawaiian people organized into the Hui Hawai'i Aloha 'Āina or the Hawaiian Patriotic League, composed of both men and women branches, which opposed any treaty of annexation and remained civically engaged (Sheldon, 1908; Silva, 2004). One was the Hui Aloha 'Āina o Na Wahine or the Hawaiian Patriotic League for Women. The Pelekikena Nui was Mrs. Abigail Kuaihelani Campbell-Parker. The other group formed on March 4, 1893, Iosepa Kaho'oluhi Nāwahīokalani'ōpu'u became a founding member of Hui Aloha 'Āina o Na Kane (Hawaiian Patriotic League for Men), a patriotic group founded shortly after the overthrow of the monarchy to oppose annexation and support the deposed queen. He was elected the President of the Hawaiian Patriotic League in 1893.

In January 5 of 1895, a counter revolution led by Robert Wilcox attempted to derail the annexation, but the armed revolt was suppressed by forces of the Republic. The leaders of the revolt were imprisoned along with Queen Lili'uokalani, who was jailed for failing to put down the revolt. In the summer of 1897, this same Hawaiian Patriotic League, along with the Hui Aloha 'Āina o Na Wahine or the Hawaiian Patriotic League for Women, would initiate an island-wide anti-annexation petition. More than 21,200 people would eventually sign these Kū'e Petitions. This represented about half of the Hawaiian population at the time (Silva, 1998). Representatives of the Hui traveled to Washington D.C. in 1897 and met with the Queen, who was staying there, to strategize. They presented their petition to members of the U.S. Senate, and remained steadfast aloha 'āina who inspire a new generation of patriots and protectors (Silva, 2004).

... leaders of the
revolt were imprisoned
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Lili'uokalani ...

Mission-Oriented Legacies and Entrusted Organizational Leadership

Those legacies of the late nineteenth century remain with kānaka maoli in present day through organizations entrusted during the political leadership shifts described in this section. With benevolent missions to serve the Hawaiian people, these organizations serve as community leaders in their own respect. By their success and achievements, empowerment and well-being is gained through advocacy, support services, direct education, land stewardship, and mission-oriented, sustainable identities.

LUNALILO HOME & TRUST

- » MISSION STATEMENT: To provide respectful, quality, compassionate, and caring services for disadvantaged kupuna of Hawaiian ancestry.
- » BACKGROUND: Lunalilo Home was established by the will of High Chief William Charles Lunalilo, who died in 1874 while he was king of the Hawaiian Islands. His estate included large landholdings on the five major islands, consisting of 33 ahupua'a, nine 'ili, and more than a dozen home lots. His will established a perpetual trust under the administration of three trustees to be appointed by the justices of the Hawaiian Supreme Court. King Lunalilo was the first of the large landholding ali'i to create a charitable trust for the benefit of his people. The purpose of the trust was to build a home to accommodate the poor, destitute, and ailing people of Hawaiian blood or extraction, with preference given to older people (OHA, 2013, p. 4).

THE QUEEN EMMA LAND COMPANY

- » MISSION STATEMENT: To fulfill the intent of Queen Emma and King Kamehameha IV to provide in perpetuity quality health care services to improve the wellbeing of Native Hawaiians and all the people of Hawai'i.
- » In his first speech, King Kamehameha IV, Alexander Liholiho, stated the need for a hospital to treat the native population. The Hawaiian population had plummeted due to introduced diseases. The extinction of the native populace was a very real possibility. Queen Emma and her friend Queen Victoria, helped to fund worthy causes, among which was the first hospital in Hawai'i, organizing a hospital auxiliary of women to help with the ill. To recognize and honor Emma's efforts, it was decided to call the new hospital "Queen's." The original building, housing just 18 patient beds, opened its doors on August 1, 1859. Within a year, a much larger building with room for 124 beds was built on the same site where The Queen's Medical Center stands today (OHA, 2013, p. 5).

THE QUEEN LILI'UOKALANI TRUST

- » The Queen Lili'uokalani Trust was born out of the aloha and care that a loving Queen had for the children and families of Hawai'i.
- » "...He will keep His promise, and will listen to the voices of His Hawaiian children lamenting for their homes. It is for them that I would give the last drop of my blood; it is for them that I would spend, nay, am spending, everything belonging to me." This powerful and moving quote by Queen Lili'uokalani serves as an inspiration for us to perpetuate her legacy of care and compassion for the orphan and destitute children of Hawai'i (OHA, 2013, p. 6).

KAMEHAMEHA SCHOOLS

- » MISSION STATEMENT: Kamehameha Schools' mission is to fulfill Pauahi's desire to create educational opportunities in perpetuity to improve the capability and well-being of people of Hawaiian ancestry.
- » Kamehameha Schools is a private charitable educational trust endowed by the will of Hawaiian Princess Bernice Pauahi Bishop (1831-1884), the great-granddaughter and last direct descendant of King Kamehameha I. During her lifetime, Princess Pauahi witnessed the rapid decline of the Hawaiian population. With that decline came a challenge to preserve the Hawaiian language and culture she held dear. The princess knew that education would be key to the survival of her people, so in an enduring act of aloha, she left them a precious gift upon her passing—375,000 acres of ancestral land. She instructed the trustees of her estate to use the land to educate her people. Today, her endowment supports an educational system that serves thousands of Hawaiian learners in Hawai'i and across the nation (OHA, 2013, p. 3).

DEPARTMENT OF HAWAIIAN HOME LANDS

- » VALUE STATEMENT: To ensure the Hawaiian Home Lands Trust is on a solid foundation with sound policies and procedures, a long-term sustainable financial plan, a commitment to serving beneficiaries, and an organizational culture that honors the spirit of its founder, Prince Jonah Kūhiō Kalanianoʻole. With the foundation firmly rooted, administrations going forward will be prepared to work side-by-side with beneficiaries and other partners to create and maintain vibrant homestead communities. (OHA, 2013, p. 2)
- » The primary responsibilities of the Department of Hawaiian Home Lands are to serve its beneficiaries and to manage its extensive land trust. The land trust consists of over 200,000 acres on the islands of Hawai'i, Maui, Lāna'i, O'ahu and Kaua'i.

THE OFFICE OF HAWAIIAN AFFAIRS

- » MISSION STATEMENT: To mālama Hawai'i's people and environmental resources and OHA's assets, toward ensuring the perpetuation of the culture, the enhancement of lifestyle and the protection of entitlements of Native Hawaiians, while enabling the building of a strong and healthy Hawaiian people and nation, recognized nationally and internationally.
- » The Office of Hawaiian Affairs was born of a collective and compassionate effort on the part of the delegates to the state Constitutional Convention of 1978. They spoke to a sense of justice, to the righting of wrongs suffered by the indigenous people of the Hawaiian Islands for exactly 200 years. The arrival of Captain Cook in Hawai'i had brought not only increased contact with the world beyond the islands' pristine shores, but also diseases that devastated the native population, and a way of life that depressed the circumstances of those remaining (OHA, 2013, p. 1).

... building of a strong
and healthy Hawaiian
people and nation,
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and internationally.

O Kēia Au

There are numerous fellowship and scholar programs, such as the Mellon-Hawai'i Doctoral and Postdoctoral Fellowship Program, First Nations' Futures Program, Hawaiian Scholars Doctoral Fellowship Program, 'Ōiwi Leadership Institute, Office of Hawaiian Affairs and University of Hawai'i's Native Hawaiian Science and Engineering Mentorship Program Scholarship, Chaminade University's and Kamehameha Schools' Ho'oulu STEM Scholars Program, and the Native Hawaiian Health Scholarship Program. Each of these programs offer training workshops, personalized mentoring, a cohort of peer leaders, and ways to access institutions for academic and professional growth. Additionally, some of these programs create leadership development opportunities such as public speaking, knowledge exchange events, and project-based collaboration. Unique leadership development programs like these, which typically run for one to four years, go beyond simply providing scholarships to Native Hawaiian students and young professionals. They actively cultivate the mana within each kanaka who joins their 'ohana.

New programs are sustained every year and offer innovative leadership models for ka wā mahope (future era): The Department of Native Hawaiian Health's Summer Research Internship Program provides early learning opportunities to be trained in clinical, community-based, translational research, and medical curriculum for undergraduate haumāna (students). MA'O Farms' Youth Leadership Training program creates diversified opportunities in agriculture, education, and economic development for 'ōpio from the Wai'ane Coast aged 17–24. The Kamehameha Scholars program is designed with servant leadership values for Native Hawaiian students in grades 9–12. Other programs offer targeted learning opportunities for children and families such as Ehuola at Kōkua Kalihi Valley Comprehensive Family Services which seeks to establish a strong foundation of 'ai pono and a strong foundation of cultural practice which is 'āina-based. Mā'ilikūhahi 'Āina Momona Academy partners with numerous non-profits organizations to create immersive opportunities for

keiki ages 3 to 12 that develop their hands-on knowing of stewardship, harvesting, food cultivation. Ma Ka Hana Ka 'Ike approaches community needs in Hāna with at-risk youth who come together through place and projects which build self-sustenance, community relationships, and cultural connections. At Hui Mālama i ke Ala 'Ūlili (huiMAU), keiki in the Hō'ale a Maninini (HoAMa) program are creating abundance in their ahupua'a, with their 'ohana, and for the lāhui as young leaders regenerating mana in Hāmākua.

There are also numerous awards and ceremonies throughout the year which honor loa and kūpuna for their life's work and contributions to the Native Hawaiian community and Hawai'i. Efforts to praise and congratulate our leaders is a mechanism to mahalo while one way to simultaneously revitalize excellence in civic engagement. Throughout the year, organizations come together in fellowship and celebration for kānaka luminaries such as the Nā Mamo Makamae o Ka Po'e Hawai'i: Living Treasures of the Hawaiian People from the Office of Hawaiian Affairs; the Honpa Hongwanji Mission of Hawai'i's Living Treasures of Hawai'i program; the Ō'ō Award, by the Native Hawaiian Chamber of Commerce; the Native Hawaiian Education Association's Educator of the Year; the Papa Ola Lōkahi Native Hawaiian Health Award; the West Honolulu Rotary Club's David Malo Awards; the Kalani Ali'i Awards by the 'Aha Hipu'u; the Kamehameha Schools' Native Hawaiian Community Educator of the Year award; and among others among the Association of Hawaiian Civic Clubs and royal societies.

Contemporaries of kāhuna, kālaimoku, and kāula lineages influence each generation to come. Opportunities to celebrate gains and successes are also examples of everyday leadership which sometimes begin with a small flame and then increase to be a light for guidance. As described in the 'ōlelo no'eau—kū ka lau lama—when many torches stand together, they become bonfires, and signal joy and victory.

Interventions & Recommendations

The mana of the akua wāhine shared throughout this report cannot be overstated: their skills and expertise are a part of our genealogical identity of who we are today; the places where they dwelled are wahi pana to protect and preserve as sacred today; and their legacy is a part of this generation to perpetuate so young kaikamahine of the future may be guided by their enduring strength. Inspired by the places, sites, and ‘āina referenced throughout this report and the community programming which currently exists, we recommend that place-based mentoring be supported regionally. By increasing place oriented immersion and education opportunities, the history of place and mana of the pae moku (archipelago) will critically influence the next generation through positivity and strength. These might be specifically tailored for wāhine to include practices and protocol related to females or may also include ‘ohana members for cross-sharing.

Contemporary wāhine leaders can inspire the next generation by openly sharing topics related to leadership struggles, including work/life balance, multitasking, glass ceiling effects, sexual harassment, and discrimination by gender. Becoming a role model within a community or field-of-work can begin at any age or stage. Research in Hawai‘i has shown that these approaches can build protective factors and help high risk keiki overcome the odds (Werner & Smith, 1992). Informal sharing and opportunities for guidance can be made available through community-based non-profits with deep ties to their respective network and within organizational business models.

Wāhine leadership in the workplace can be supported when organizations:

- » Create opportunities for promotion in middle management and executive levels.
- » Incentivize professional development and career goal-setting among staff.
- » Provide educational benefits and scholarships for employees who seek certification training or postsecondary degrees while remaining employed.
- » Address unbalanced “administrative tasks” and “household chores” around the workplace among staff, taking special notice if these tasks become inequitable.

- » Encourage multiple types of personalities and work styles within projects, with care toward taking positive action when conflicts arise.

Wāhine leadership within academic environments can be encouraged when schools:

- » Create a positive school climate that promotes the emotional well-being and growth of every student.
- » Nurture leadership skill development for students during the middle years of schooling (grades 6 – 8).
- » Develop a “student voice” when designing school-based interventions, and include adolescents in decision- and policy-making processes. They are often a force of change themselves and are transitioning into more independent roles, with the willingness to take part in political processes.
- » Determine if discipline policies and procedures are effective and fair for all students.
- » Establish school-based intervention frameworks specific to geographic location; resource whole-school prevention programs with risk warning systems to identify vulnerable students at your school.

Improving wāhine leadership in the community remains an essential foundation to empower wāhine and strengthen all of Hawai‘i. Inspired by the leadership and civic kuleana of the many wāhine featured throughout this report, we recommend the creation of a leadership model for young girls and ‘ōpio through adulthood. Where one generation supports and uplifts one another because the stories, experiences, and barriers are familiar. In order to empower a generation of wāhine well-being, leadership skills woven with Hawaiian cultural strengths would enhance their ability to step into the kuleana of leadership when they are ready.

By creating a model for cultivating leadership through mana wāhine, we can all work together as sisters, cousins, aunties, mothers, and tūtū for our ‘ōpio to connect with that part of their na‘au—na‘au filled with leadership potential at the highest levels. Such a model could be developed with aims to energize women in business, finance, sciences, health, law, natural resources, education, economics and government. Most importantly, to support girls grounded in ‘ike ku‘una (traditional knowledge) will no doubt influence the importance of cultural intelligence across their development and the embodiment of the lāhui o ka wā mahope.

CELEBRATING TWENTY MANA WĀHINE FROM THE LAST CENTURY:

Which wāhine trailblazers inspire your field?
We encourage you and your networks to share the great works of wāhine, past and present.

1. 'Iolani Luahine: Master of sacred traditional practices
2. Ma'iki Aiu Lake: Champion of the Hawaiian hula renaissance
3. Helen Laka Kanahele: Labor and women's rights advocate
4. Emma Metcalf Nakuina: First wāhine Water Commissioner, established water laws
5. Mary Frances Oneha: First Native Hawaiian registered nurse with a PhD
6. Kini Kapahu Wilson: 1919 women's rights
7. Isabella Kauakea Yau Yung Abbott: First wāhine PhD in a science discipline
8. Debbi Akiona Eleneki: First female firefighter at Honolulu Fire Department in 1987; first female fire captain at HFD in 2005
9. Melody Kapilialoha MacKenzie: First Director, Ka Huli Ao Center for Excellence in Native Hawaiian law; founding member of the Native Hawaiian Bar Association
10. Lilikalā K. Kame'eleihiwa: Trailblazing academic; author of *Nā Wāhine Kapu (Sacred Hawaiian Women)*
11. Kauanoe Kamanā: First wāhine doctorate in the field of revitalizing indigenous languages; co-founder of Pūnana Leo
12. Davianna Pōmaika'i McGregor: Founding member of Ethnic Studies at the University of Hawai'i, Mānoa
13. Noreen Mokuau: First Hawaiian doctorate in Social Welfare; first Native Hawaiian dean of the Myron B. Thompson School of Social Work
14. Maenette Benham: First Hawaiian doctorate in Education; first wāhine chancellor; first dean of Hawai'i inuiākea School of Hawaiian Knowledge; first Native Hawaiian dean at UH Mānoa
15. Marjorie Mau: First wāhine ranked "master physician" by the American College of Physicians
16. Diane Paloma: First wāhine CEO of Lunalilo Trust & Home
17. Roberta Apau Ikemoto: First wāhine physician
18. Chiyome Leina'ala Fukino: First female Director, Department of Health, State of Hawai'i
19. Frenchy DeSoto: First board chair of the Office of Hawaiian Affairs; leader of the 1978 Constitutional Convention
20. Lolena Nicholas: Kupuna-in-residence; advocate for Hawaiian Language Immersion Programs; leader in Ni'ihau community

Part of a Legacy of Leadership

As a leader, Diane S.L. Paloma, MBA, Ph.D., is guided by the vision of ali'i who walked before her.

In 2017, Dr. Paloma was named the first CEO of The King Lunalilo Trust and Home. Prior to that, she directed the Native Hawaiian Health Program at The Queen's Health Systems. But when asked about leadership, she refers to herself first as a beneficiary.

"Kamehameha Schools and Pauahi's mission instilled in me the concept of giving back to your community with no expectation of return," says Paloma, a 1991 KS graduate and Pauahi Foundation scholarship recipient. "I had the privilege of working for Queen Emma and King Kamehameha IV, and now, to be able to work now for Lunalilo, I am able to continue what those ali'i foresaw in giving to their people."

A prominent voice in policy discussions about Native Hawaiian health equity both locally and nationally, Dr. Paloma is troubled that today's health system is designed to diagnose illnesses, treat them, and move on—as opposed to addressing the overall health of an individual. While recent technology and medical interventions are improving outcomes for women suffering from disease and chronic conditions, more progress must be made to bring about positive, long-term health changes. One way to treat the patient holistically is through traditional care practices.

Experience has shown Paloma the value of integrating culture into medical practice, applying traditional techniques like lā'au lapa'au and ho'oponopono alongside advanced treatments like chemotherapy. As a breast cancer survivor, she also has a patient's perspective. In 2013 at age 40, the mother of three was diagnosed with the disease that claimed both of her grandmothers, and she started treatment immediately. Now 44, she notes that her daughters don't see cancer as a devastating disease, but rather as something temporary to beat,



overcome, and grow from. "What I really hope for my three daughters and the rest of the lāhui is that we come to a point where we don't have to suffer anymore from these chronic diseases."

Achieving lāhui health requires coming together as a community to find solutions. "It's a collective. It's a kākou thing. I think that Hawaiians understood that very well in terms of land use management. If you look at our ahupua'a system, they understood that each component had a role and had this important role in the functioning of the entire community. In terms of healthcare today, that sense of ahupua'a is siloed."

In addition to community cooperation, Paloma sees workforce equity as part of the solution, along demonstrated respect toward women, kupuna, and mothers. "These are so critical in building this long pipeline of wāhine leaders and mana wāhine who are in the community doing their work every day, no matter what industry they're in."

"I think if we elevate those elements of mana wāhine, that's how we get to Native Hawaiian health and well-being," she continues. "It's not just the elimination of the disease, not just addressing illness or chronic disease, but being able to help women sustain economic viability. That begins with a lot of legislation. It begins with people changing their philosophy on what it means to be a Hawaiian woman in Hawai'i today."

Revisiting the topic of leadership, Paloma says, "I think my style, and my 'ano is that I'm going to demonstrate leadership by doing the things that I promised, by keeping it operational, keeping it within a budget, being able to demonstrate my work through the things that I've created or done, rather than talking about it or promising. To me, that stems from a lot of learnings through hula and other areas of Hawaiian studies where you show worth by doing, not by listing or degrees on the wall."

Summary

Who we are as wāhine Hawai‘i is built upon a foundation of mana that was passed to us through the nurturance, connection, brilliance, engagement, leadership, and strength of our kūpuna.

Lilikalā Kame‘eleihiwa reminds us that “as Hawaiian women, we are the intellectual as well as the physical descendants of our female ancestors, and in turn we will be ancestral inspiration for the generations to come” (2002, p. 1). Our legacy stems from strong mothers, our ancestors’ special care, emotional well-being and lā‘au as the embodiment of the natural resources within our homeland. Relationships built between families and community was the foundation for our social, emotional and mental wellness. Cultural practices for everyday life, advanced learning through specific ‘oihana and subsistence in our ahupua‘a. Our Hawaiian genealogy of leadership is filled with strong wāhine ali‘i who committed their lives toward the betterment of their people. Their legacy remains within each of us today and each one of our wondrous bodies, our eightfold bodies, four thousand bodies, four hundred thousand bodies, as wāhine Hawai‘i. It is in embracing that kuleana that we as Hawaiian females in the present day can step into our role for cultivating and restoring our well-being as Hawaiian women. When one of us is well, in balance and full of ola, and eight of us, and four thousand of us, so too shall our ‘ohana, our Hawaiian communities, and the lāhui and that which has been birthed within our archipelago by Haumea.

In closing, just as we opened this report with the Kumulipo in honor of the Hawaiian oral history of our creation, we similarly close this document with a prayer to reinforce the spiritual role of wāhine Hawai‘i in our identity. This prayer was located in the archives of the Bernice Pauahi Bishop Museum within the Poepoe Collection, as “Na Aumakua Wahine”. In ka wā kahiko, it was used to call upon the chiefly ‘aumākua who granted health for the sick. These ‘aumākua possessed the mana wāhine to ward off any trouble caused by sorcerers of ancient times. Thus they were called upon by wāhine and kāne alike for their female power, individual strength, and collective force. These ‘aumākua were said to be protectors of their worshippers and were greatly worshipped by ali‘i and kahuna nui of that time, ka wā mamua. Together, we pani this step toward *Transforming the Health of Native Hawaiian Women and Empowering Wāhine Well-Being*. It is not simply in reverence to Haumea, but also to Kaha‘i, Hi‘iaka, Pele, Kauhola, Kalahiki, Kauwela, Ho‘aka, Kuna‘ioha, Moe‘uhane, Laea, Kamalei, and the thousands of wāhine from whom they call kaikuahine, kaikua‘ana, kaikaina, makuahine, kūpunawahine, mo‘opuna wahine, luahine, ‘elehine, wahine ho‘owahine, wahine makua, wahine o ka pō, haku wahine, and ali‘i wahine.

Ia oukou e na aumakua wahine,
 Mai ka la hiki a ka la kau,
 Mai ka la kau a ka la hiki,
 Mai ka paa iluna a ka paa ilalo,
 Mai ka hookui a ka halawai,
 E hoohalawai mai oukou,
 Ia oe e Kahai, e Haumea, e Hiiaka,
 E Pela, ka wahine ai laau o Puna,
 o Kauhola mai, O Ka-la-hiki, O Kauwila,
 o Kaoaka, O Kunaioha, O Moehaune,
 Na wahine maka kai,
 o Laea ka wahine kua waa,
 o Kamalei ka wahine o ke komohana,
 Na aumakua i kuli, i lohe ole i ka'u olelo,
 E hoolohe mai i ka'u noi,
 Eia ka ma'i o (inoa) he papaku ka ma'i,
 He ma'i hooiloilo ia aole e ola,
 O ka oukou o ke ola,
 E lawe i ka eha, ke hu'i,
 Ka lia, ka molohai, ka ponaanaa.
 O ke ola, O ka ikaika maikai,
 Oia ka oukou e haawi mai ai,
 Amama, ua noa.

*To you, O goddesses,
 From sun rise to sun set,
 From sun set to sun rise,
 From the firmament above to the earth below,
 From the zenith to the horizon, (i pray)
 Come ye together.
 To thee o Kahai, Haumea, Hiiaka,
 Pele, the goddess who devours the forests of Puna,
 And to thee, Kauhola, Kalahiki, Kauwila,
 Hoaka, Kunaioha, Moehaune
 The women whose faces are hidden in the seam
 o Laea, goddess of canoe builders,
 o Kamalei, goddess of the west,
 Goddesses who are deaf, who listened not to my words,
 Listen to my plea.
 Here is the patient (so and so) sick with the papaku,
 A sickness said to be incurable,
 May your gift be health to [her].
 Take away the soreness, the pains,
 The chills, the drowsiness, the heaviness of the head.
 May health and strength
 Be given [her] by you.
 Amen, it is freed.*

(Source: Poepoe Collection, Box K6. Translated by Mary Kawena Pukui.)

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About This Series

This publication is the second report in a three-part series by the Office of Hawaiian Affairs (OHA). The first is dedicated to kāne and Native Hawaiian males which is *Kānehō‘ālani: Transforming the Health of Native Hawaiian Men*, which launched in June 2017.

Kānehō‘ālani (OHA, 2017) builds upon the *E Ola Mau* study, which was developed by a group of scholars in the mid-1980s and led to the passage of the federal Native Hawaiian Health Act. The report tracks health across an individual’s lifespan from, keiki to kupuna, while also examining how many different factors impact health, such as education, occupation, incarceration and housing—collectively referred to as the social determinants of health. The report also underscores the important role of males in traditional Hawaiian customs, which may offer a cultural roadmap to improve health outcomes (Office of Hawaiian Affairs, 2017b).

To view and download a free copy of *Kānehō‘ālani: Transforming the Health of Native Hawaiian Men*, please visit <http://www.oha.org/kanehealth>.

The third and final part of the series will be dedicated to ‘ohana, Native Hawaiian families. Topical areas will include family demographics, housing, homelessness, and explore protective factors like protective factors, social connections, and connection with family development and strengthening programs. Culturally founded topics will include ho‘oponopono, hānai and ho‘okama, māmū, family gods, and familial traditions that have been passed from one generation to the next. Within this publication will feature special attention to transgender non-binary kānaka whose role are important within our diverse ‘ohana. This third publication is expected to be released by the end 2019.

NAMING

Throughout this research, we made special effort to note plant, flower, food, tree names to indicate the connection of our customary practices with living resources. Such resources should be protected in order to claim our connection to traditional and customary practices as described in the stories, legends, chants, prayers, and songs.

COVER ARTWORK: “HAUMEA”[©] BY NAI’A-ULUMAIMALU LEWIS

A creative collaboration with the Office of Hawaiian Affairs, Ho’omaika’i LLC, and And Still the Waters Rise this cover and internal visuals of Haumea honors the role and legacy of wāhine through original artwork.

Artist’s Note: MOTHERHOOD is represented by Haumea standing in the lo’i kalo and merges into the ancient forest, which feeds each generation. Her hair is the wind and streams, and the mana that births each generation. MENTAL & EMOTIONAL WELLBEING is created on a daily basis like the sun rising each day. The rays shine light on the truth of our greatness. PHYSICAL HEALTH emerges like a butterfly when one takes the time to commit to a lifestyle that promotes growth. Our physical perpetuation of Hawaiian values is life-giving. PARTNER VIOLENCE & INCARCERATION is symbolized by the male figure who is injured physically, emotionally and spiritually—but is being healed by the mana being sent to him through the hair of Haumea. He is also standing in the lo’i taking in the healing of his ancestors. ECONOMIC WELL-BEING is strengthened when we care for our natural and cultural resources. From fishing to solar power our islands have the ability to sustain us and our wellness for generations more. LEADERSHIP & CIVIC ENGAGEMENT comes from being able to soar above the issues and see the connections between people and place, between the mundane and the sacred, between the wao akua and wao kānaka.

About the Office of Hawaiian Affairs

VISION

“Ho’oulu Lāhui Aloha”—To Raise a Beloved Nation. OHA’s vision statement blends the thoughts and leadership of both King Kalākaua, and his sister, Queen Lili’uokalani. Both faced tumultuous times as we do today, and met their challenges head on. “Ho’oulu Lāhui” was King Kalākaua’s motto. “Aloha” expresses the high values of Queen Lili’uokalani.

MISSION STATEMENT

To mālama (protect) Hawai’i’s people and environmental resources and OHA’s assets, toward ensuring the perpetuation of the culture, the enhancement of lifestyle, and the protection of entitlements of Native Hawaiians, while enabling the building of a strong and healthy Hawaiian people and nation, recognized nationally and internationally.

OVERVIEW

The Office of Hawaiian Affairs is a public agency with a high degree of autonomy. OHA is responsible for improving the well-being of Native Hawaiians.

OHA is governed by a Board of Trustees made up of nine members who are elected statewide for four-year terms to set policy for the agency.

OHA is administered by a Ka Pouhana (Chief Executive Officer) who is appointed by the Board of Trustees to oversee a staff of about 170 people.

Mana is Our Legacy, Maui Ola is Our Destiny



Mana is Our Legacy, Maui Ola is Our Destiny.

     #wahinehealth

Read and learn more online at www.oha.org/wahinehealth

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