"NHPI groups in the U.S. have unique immigration and citizenship pathways which impact experiences from geography and immigration status to eligibility for safety net programs."

BACKGROUND

Native Hawaiians and Pacific Islanders (NHPI), the indigenous peoples of Oceania, are the first people from Hawai'i and the Pacific Islands that make up Micronesia, Melanesia and Polynesia. Pasifika peoples (NHPI) include many cultures and ethnicities with diverse and rich histories, traditions, languages, and practices.

NHPI living in the United States come from many ethnic and linguistic backgrounds including Kanaka Maoli (Hawai'i); Tagata Sāmoa (Samoa); Tongan (Tonga); Vosa Vakaviti (Fiji); Chuukese, Ifalikese, Kosraean, Pohnpeian; Yapese (Federated States of Micronesia); Chamorro (Guam), Marshallese (Marshall Islands); and Palauan (Palau). NHPI are one of the fastest growing ethnic groups in the United States—over 150 million people in the U.S. identify as NHPI.[1,2]

Native Hawaiians, Kanaka Maoli, are the first people of the land that makes up the current state of Hawaii, the land of the Kingdom of Hawai'i. Kanaka Maoli, like other Pacific Islanders, experienced good population health including robust indigenous healing and medical practices, sovereignty, connection to the land ('āina), and conflict resolution practices.[3,4] Colonization and imperialism brought mass disease, conflict, changing food systems, and many socioeconomic forces that resulted in harm to physical and cultural health.

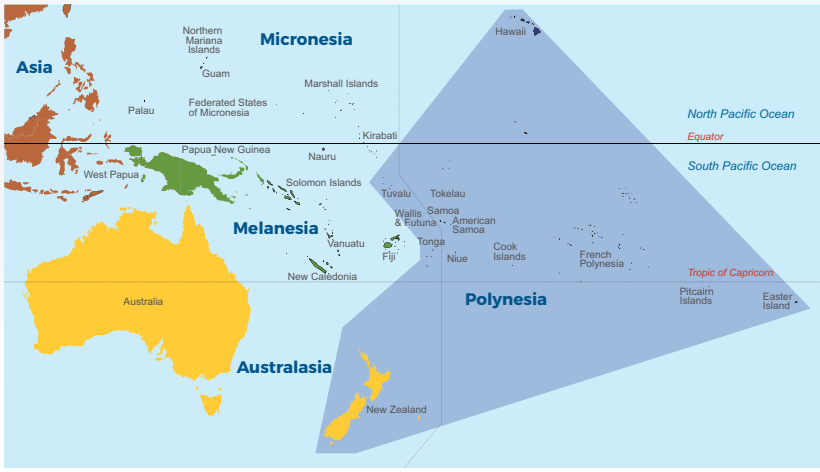

Image source: Wikimedia Commons

Like other Pacific Islanders, many Kanaka Maoli in recent decades have been displaced throughout the contiguous U.S. due to the continued impact of colonization and economic disenfranchisement. In the face of these challenges, NHPI communities in the U.S. continue to persevere to retain and revitalize their languages, cultures and communities.

NHPI groups in the U.S. have unique immigration and citizenship pathways which impact experiences from geography and immigration status to eligibility for safety net programs. For example, those born in Marshall Islands, Palau, and Federated States of Micronesia have lawful non-immigrant status as part of The Compact of Free Association (COFA), a response to forced displacement caused by U.S. military testing.

Almost 70 nuclear weapons were tested in the Marshall Islands, causing long-term health problems and environmental destruction.[5,6] People born in Guam and the Northern Mariana Islands are U.S. citizens by birth, while those born in American Samoa are U.S. Nationals, a more restricted status.

With histories and current realities deeply impacted by climate and environmental justice, Pasifika communities have continued to lead in fights for justice, health and equity, and climate justice.

The scope of this toolkit focuses on NHPI living in the states, however, NHPI in the U.S. also includes U.S. citizens and nationals living across territories in the Pacific.

CURRENT STATE OF HEALTH EQUITY AMONG NHPI COMMUNITIES

SOCIAL DETERMINANTS OF HEALTH (SDOH) AND HEALTH-RELATED SOCIAL NEEDS (HRSN)

> *"The "United States' colonial, post-colonial, and military actions in the region have resulted in adverse socioeconomic, health, and environmental pollution-related legacies among local and Indigenous [NHPI] populations"* [7]

NHPI communities in the U.S. retain unique cultures and histories, as well as some varying trajectories and barriers in the U.S, and at the same time share many common experiences, histories, values and practices.

Overall, NHPI experience disproportionate health burdens regardless of where in the U.S. they live, stemming from the legacies of U.S. colonization and imperialism in Hawaii and the Pacific islands.

Indigenous Social Determinants of Health (ISDoH)

Like Native Americans and Alaska Natives, NHPI public health includes indigenous determinants of health or indigenous social determinants of health (ISDoH). In addition to the SHoH that affect all communities and individuals, ISDoH include factors such as:

- the impacts of historical trauma and ongoing impacts of colonization and imperialism
- racism and discrimination
- displacement and environmental destruction
- sovereignty
- cultural wellbeing
- connection to the land and sea and traditional food systems[4]

Displacement: Many NHPI have been already displaced from their native lands and continue to experience additional displacements due to cost of living and other factors. Displacement represents an underemphasized social determinant of health which has wide-ranging impacts on physical and mental health.

Historical trauma: CHW respondents highlighted the impact of historical trauma as a key driver of the health inequities, burdens, and barriers experienced by NHPI communities. Many CHW-led innovations accounted for the impact of historical trauma and need to help people feel connected to culture and community in response to the overlapping historical traumas and displacement.

Social determinants of health (SDoH) impacting many NHPI communities include:

- **High cost of living and high rates of poverty:** As a group, NHPI experience high rates of poverty and uninsurance.[8]
  - Native Hawaiians (Kanaka Maoli): The most expensive state to live in, the cost of living in Hawaii is almost 80% above the national average.[9] Native Hawaiians experience the highest poverty rates of the major racial and ethnic groups in Hawaii.

- Marshallese: Despite the U.S. government's acknowledged destruction and resulting forced displacement, treaties have provided very limited restitution. Almost 30% of Marshallese (27%) live under the federal poverty level, along with 16% of NHPI overall in U.S. -- greater than the national average (12.6%). Much greater numbers live close to the poverty level.[8,10]
- CHW survey respondents highlighted the harmful impacts of extremely high cost of living in states like Hawaii and lack of affordable housing on the communities they serve.

- **Immediate basic needs:** Socioeconomic forces have caused crises of housing and food insecurity along with ongoing barriers to education and employment—necessary milestones that allow people to maintain basic needs.
  - CHW participants across all WWTS topics described how high levels of immediate basic needs results requires significant time and attention, delaying their ability to focus on securing and building sustainability toward longer term individual and community needs.
- **Access to healthcare:** CHW survey participants highlighted barriers to healthcare access among NHPI including lack of culturally informed care, language access, transportation, and availability of healthcare services. CHWs explained that historical trauma, cultural misalignment, and access barriers have resulted in mistrust of western healthcare systems and providers.

  Also documented are high rates of uninsurance or barriers to health insurance coverage, discrimination and prejudice,[11] and low utilization of services.[12]
  - Transportation: Due to limited availability of healthcare services especially in rural areas, transportation poses a significant barrier and can require traveling to other islands for care. This is especially challenging for kūpuna (elders).
- **Chronic health conditions:** NHPI communities experience disproportionately high rates of diabetes, identified as an epidemic within NHPI communities,[13] hypertension, and other chronic conditions.[12,14]
- **Mental health and substance use:** Mental health is linked to many health and social challenges among NHPI, including suicide, violence, substance use, incarceration, and homelessness.[15]
  - Mental health and substance use burdens were highlighted by CHW respondents including depression, suicide, and violence (including domestic and sexual violence), stemming from historical trauma and cumulative impacts of colonization, dispossession and displacement.
- **Special populations:** CHW survey respondents highlighted groups experiencing additional health burdens within the NHPI population including older adults (kūpuna (Hawai'i)), children (keiki (Hawai'i)), women, people with low technology comfort or access, people with disabilities and/or chronic health conditions (including mental health), rural residents, and people with a primary language other than English.[15]

POLICY AND PRACTICE HIGHLIGHTS

Most peer reviewed research on CHW interventions serving NHPI focuses on interventions targeting one condition or disease such as diabetes or breast cancer screening. Fewer focused on mental health and other risk factors and health related social needs.[16]

Data disaggregation: Data on NHPI health needs and outcomes have often failed to reflect the diversity of the NHPI population, frequently grouping NHPI and Asian Americans together as one group. Policies and efforts to disaggregate

public health data aim to allow for better understanding of the health needs and outcomes of NHPI ethnic groups.[1,17]

Policy and systems change successes have addressed ISDoH/SDoH and aim to improve NHPI community health capacity through tailored approaches, including:

- The Native Hawaiian Health Care Improvement Act most recently amended in 1992, established Papa Ola Lokahi, the organization tasked with planning and overseeing the Native Hawaiian Healthcare System, reduced barriers to healthcare access, services for remote patients, recognizes traditional healers.
- AlohaCare, a Medicaid provider in Hawaii, has incorporated some Native Hawaiian healing practices as "value added services," including Ho'oponopono (relationship balance and healing), lomilomi (Native Hawaiian physical therapy and massage), some la'au lapa'au (Native Hawaiian medicine and herbal remedies).
- Medicaid and benefit restoration for COFA citizens so that those present under COFA can access needed healthcare, SNAP, and earned social security which they had been denied.

CHW ROLES SERVING NHPI COMMUNITIES

CHWs work within and across community and clinical settings creating a web of support for NHPI community members.

Within the public health literature, CHW interventions serving NHPI include health education and counseling, recruitment, community outreach, and follow-up with participants. While these represent critical CHW roles, they do not represent the full scope of CHW efforts serving NHPI communities identified by the WWTS.

Additional roles and activities described by CHWs included healthcare and resource navigation; addressing intersecting SDoH and HRSN; advocacy; developing and carrying out innovative activities to address community health needs; cultural mediation and bridging; adapting and developing culturally relevant health education curricula; and social support, community cohesion and cultural connection.