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EXAMINING STRUCTURAL RACISM AS A CAUSE OF HEALTH INEQUITIES AMONG PACIFIC ISLAND PEOPLES IN THE UNITED STATES AND AOTEAROA NEW ZEALAND: AN EXPLORATORY COMPARATIVE CASE STUDY

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2022

APPROVAL OF THE DISSERTATION COMMITTEE

This dissertation has been duly read, reviewed, and critiqued by the Committee listed below, which hereby approves the manuscript of Jake Ryann C. Sumibcay as fulfilling the scope and quality requirements for meriting the degree of Doctor of Public Health.

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ABSTRACT

EXAMINING STRUCTURAL RACISM AS THE CAUSE OF HEALTH INEQUITIES AMONG PACIFIC ISLAND PEOPLES IN THE UNITED STATES AND AOTEAROA NEW ZEALAND: AN EXPLORATORY COMPARATIVE CASE STUDY

By
Jake Ryann C. Sumibcay

Claremont Graduate University: 2022

Native Hawaiians and Pacific Islanders (NHPI) in the United States are known to experience profound and persistent disparities across most indicators of socioeconomic status and health when compared to the majority population. Similarly, the Indigenous Māori and Pacific peoples in Aotearoa New Zealand parallel the same experiences. Reducing disparities and improving health equity among racial/ethnic minority populations have been regarded as a national priority in both the United States and New Zealand. Improved population health data have provided insights into the social determinants of health (SDoH), which has unveiled multiple factors that contribute to health disparities, including income, education, residential segregation, stress, social and physical environment, employment, and many others. Health disparities also represent a lack of efficiency within the health system. There is an increasing recognition to “dig deeper” and understand the root causes of inequities and examine the structural factors. More explicitly, how structural racism underlies the persistence of health disparities and inequities. Structural racism is defined as the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce

inequities among racial and ethnic groups. Prior research and literature suggest that structural racism exists through the evidence of racial disparities. However, verification and understanding the scope of structural racism can only be done by asking those affected about their lived experiences.

The focus of the study was to examine the extent to which structural racism is a fundamental cause of the health inequities and disparities among Pacific Islanders in the United States and New Zealand. Using a mixed-methods comparative design, a document analysis of publicly available resources (N=28) and key informant interviews (N=27) were conducted to assess the patterns of health inequities and disparities among Pacific Islanders and to understand the possible explanations through multiple contexts. The results of the analysis used in this study conceptualized the ways structural racism is operationalized. The study illustrates the experiences and forces that impact Pacific Islanders and offers insights into the wider historical and socio-political context of how structural racism affects Indigenous health. It also provides analyses of current public health practices in the United States and New Zealand.

DEDICATION

I would like to dedicated this dissertation to the people of Moananuiākea, the oceanic ancestral home and heritage region for all peoples who are Indigenous to the islands and continents touched by the waters of the Pacific. To the experts and community members that have contributed to this study, your knowledge and wisdoms are undeniable gifts, mahalo piha. And to my ancestors, who have voyaged across waters and through generations. May we continue to survive and thrive through many millenia.

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Pursue the path of challenging work.

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PREFACE

Race Consciousness and Positionality

I was born and raised in U.S.-occupied Hawai‘i. I hold privilege to have the opportunity to build a relationship and responsibility to the land, the Indigenous peoples, and communities as a keiki o ka ‘āina and a son of the Pacific. I situate myself as inherently non-Indigenous to Hawai’i or Aotearoa New Zealand and therefore do not explicitly identify as Kānaka or Native Hawaiian, nor Māori. I am a descendant of immigrants from the Philippines through the legacies of the Hawaiian Plantation Migration in the early 1900s.

My motivations for this project stem from my familial and cultural connection and upbringing within and beyond the scope of my Island home. I take accountability for our shared histories, and I stand for decolonization by decentering myself when working with our communities to address the issues of colonialism, systemic racism, and improving health and wellbeing. To facilitate the study, it was important to build pilina or a respectful relationship with those from whom I am seeking knowledge and information. I take a critical approach to build my consciousness around the perspectives of Indigenous and Pacific cultural values to ensure reciprocal, respectful relationships that extend beyond the ethics and primary focus of this work.

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CHAPTER 1: Introduction

Background

Native Hawaiians and Pacific Islanders (NHPIs) in the United States (U.S.), in comparison with other social groups (racial or ethnic) have experienced significant population growth over the last two decades. From 2000 to 2010, the NHPI population grew by 40 percent to 1.2 million or 0.4 percent of the U.S. population (U.S. Census Bureau, 2018). However, relative to their population size and growth, little is known about this population. The limited studies on NHPIs in the U.S. have noted that this population faces significant disadvantages such as poor health and low socioeconomic status and experiences persistent and pronounced disparities across multiple indicators compared to other population groups such as Non-Hispanic Whites (Morisako et al., 2017). Other studies on Pacific Islanders, such as in Aotearoa New Zealand have also generated similar patterns of health and socioeconomic disparities among its Indigenous Māori and Pacific Islander populations when compared to European White populations. New Zealand is known to have a reputable health system and one that is generally high performing compared to other industrialized countries providing universal coverage and publicly funded access to a large set of core health services (OECD, 2017). The U.S. remains the only industrialized country without universal health care and is in need of meaningful health reform. The health system in the U.S. has been criticized as highly fragmented and the most expensive compared to other countries (Squires & Anderson, 2015). Its serious gaps and inequities have a disproportionate impact among certain populations including NHPIs. Health is multidimensional and is determined by several factors, including the health system, education, economic stability, and environment, also known as the social determinants of health. Reducing disparities in regard to the social determinants of health and access to quality care have been longstanding national priorities for both the U. S. and New Zealand. Health and social care systems are responsible for creating a fairer society and ensuring the equitable distribution of good health for all members of the population.

Statement of the Problem and Purpose

Despite New Zealand's health and social care system providing universal care and access to a range of social benefits, the health and socioeconomic statuses of the Indigenous Māori and Pacific Islanders do not fare better compared with the NHPIs in the U.S. The parallel of patterned disparities and inequities experienced by Indigenous Pacific Islanders in the U.S. and New Zealand is not random and suggest a much broader issue, a fundamental cause of these persistent disparities and inequities beyond the access to health and social care systems.

These disparities and inequities in health might be better explained by framing structural racism as a fundamental issue. Structural racism consists of a system of institutions, ideologies, and processes that work together to generate and perpetuate racial/ethnic inequities (Gee & Ford, 2011; Powell, 2007). Public health has reached a critical point in acknowledging racism as a key determinant of health. There is an overwhelming body of evidence showing strong associations between racism and poor health outcomes across diverse racial/ethnic minority groups in developed countries (Paradies, 2015). In the U.S., the studies have predominantly been focused on the Black and African American experience due to the historical institution of slavery. Much of that existing research is focused on self-reported, interpersonal racial/ethnic discrimination, and bias. The more fundamental and broad-reaching aspects of understanding structural racism and its effect on health is limited. The study provides a comprehensive review of the health disparities and inequities experienced by Pacific Island peoples (inclusive of the Native Hawaiians and Māori, the Indigenous peoples of Hawai'i and Aotearoa) in the U.S. and Aotearoa

New Zealand, providing a robust narrative that explicitly identifies structural racism as a fundamental issue. It also gives valuable insights on Pacific Islanders, a population(s) that is understudied and often invisible in the literature.

The purpose of this exploratory mixed methods comparative study was to investigate the extent to which the persistent disparities and inequities in health and social status of Pacific Island peoples in the U.S. and New Zealand may result from structural racism.

Research Questions

The research questions below examined the extent to which structural racism explains the persistent disparities and inequities in health experienced by Pacific Islanders in the U.S. and New Zealand.

1. Does the available data identify a pattern of racial disparities and inequities for Native Hawaiian and Pacific Islanders in the U.S. and Māori and Pacific Islanders in the New Zealand?
2. How does the community perceive the cause of disparities and inequities?
3. What is the way forward to improving Indigenous Pacific Islander health and social outcomes and health equity?

Concepts and Definition of the Terms

For a better understanding of the study, the following concepts and terms were used and defined for the context of this research study

<u>Health Disparities</u>: Health disparities are defined as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to

health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (U.S. Department of Health and Human Services, 2008).

<u>Equity</u>: The World Health Organization defines equity as the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. <u>Health inequities</u> therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes (World Health Organization, 2011).

<u>Pacific Islanders</u>: Pacific Islanders is a pan-ethnic term to describe the indigenous peoples of the regions of the Pacific known as Polynesia (e.g., Hawaiʻi, Tonga, Sāmoa, and Aotearoa New Zealand), Melanesia (e.g., Fiji and Vanuatu), and Micronesia (e.g., the Marshall Islands, the Federated States of Micronesia, Guam, and Palau) (Fischer, 2002). For the purpose of this study, the groups will occasionally be identified collectively as Pacific Islanders/Indigenous Pacific Islanders or Pacific Island peoples when appropriate.

<u>Native Hawaiian and other Pacific Islanders (NHPI)</u>: In the United States, Native Hawaiians and other Pacific Islanders or NHPI refer to people having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands (U.S. Census Bureau, 2018).

Aotearoa: In this study, the use of "Aotearoa" as common usage to identify New Zealand in te reo Māori, the official language of New Zealand. The study will often use Aotearoa or the full name of the country, Aotearoa New Zealand, or New Zealand interchangeably.

Māori: The Māori are the Indigenous peoples of Aotearoa New Zealand. Under the Māori Affairs Amendment Act 1974, Māori Land Act 1993, and other statutes, a Māori is defined as "a person of the Māori race of New Zealand; and includes any descendant of such a person" (Kukutai, 2004).

Pasifika or Pacific peoples: Pasifika is an umbrella term used by the New Zealand government to describe the ethnic make of people migrating from the Pacific Islands to Aotearoa New Zealand. The term is used interchangeably with Pacific peoples or Pacific Islanders. Pacific people is exclusive of Māori and in the broadest sense covers peoples from Samoa, Cook Islands, Tonga, Niue, Fiji, Tokelau and Tuvalu (Chu, 2016).

Social Determinants of Health: The World Health Organization defines the Social Determinants of Health as the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems (World Health Organization, 2017). Healthy People 2020 emphasizes "place" as an important mechanism to assess the social determinants. Understanding the relationship between how population groups experience “place” and the impact of “place” on health is fundamental to the social determinants of health (U.S. Department of Health and Human Services, 2020).

Structural Racism: Structural racism is defined as the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups (Powell, 2007). It is a multidimensional phenomenon that shapes lived experiences through individual, interpersonal, and structural level mechanisms (Jones, 2000). The Aspen Institute also defines structural racism as a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. The term is synonymous with *systemic racism,* and it is used interchangeably. Structural racism identifies the dimensions of history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time (Lawrence et al., 2004).

Summary

This study sought to investigate the extent to which structural racism explains the persistent disparities and inequities in health experienced by Pacific Islander populations in the U.S. and Aotearoa New Zealand using an exploratory mixed-methods comparative study design. Much of the existing research is focused on racism have been on self-reported individual level and interpersonal level racial/ethnic discrimination, and bias (Groos et al., 2018; Paradies, 2015). In most previous work on racism in the U.S., the dominant narrative has focused on the Black and African America experience due to the institution of slavery. There is a knowledge gap to fill with more fundamental and broad-reaching aspects of understanding the systemic and structural aspects of racism and its effect on health. More so, this dissertation provides a comprehensive review of the health disparities and inequities experienced by Pacific Islanders in the U.S. and Aotearoa New Zealand providing a robust narrative that explicitly identifies structural racism as a fundamental issue. Four more chapters follow. Chapter 2 is a summation of the existing data and current literature that provides the foundational understanding for conceptualizing the study. It also described the theoretical concepts and frameworks that were used to guide the study, as well as the identified gaps and unique contribution that this study adds to the discourse. In Chapter 3, the topics discussed include the research design and methodology. The research results are provided in Chapter 4. Chapter 5 provides the study’s conclusions and discussion of the study’s implications and directions for future research.

CHAPTER 2: Literature Review

A Brief Overview of Pacific Islander Identities and Population Characteristics

The Pacific, also known as Oceania, has long endured human exploration and colonization since its earliest seafaring explorers, who first settled on the Pacific Islands, dating back around 1500 B.C. Between the 16th through the 20th century, European powers and Japan, and the U.S. colonized and militarized the many islands in the Pacific Basin, leaving that have marked lasting adverse impacts on the Pacific Island peoples.

Pacific Islanders are the Indigenous peoples of the regions of the Pacific known as Polynesia (e.g., Hawai'i, Tonga, Samoa, and Aotearoa New Zealand), Melanesia (e.g., Fiji and Vanuatu), and Micronesia (e.g., the Marshall Islands, the Federated States of Micronesia, Guam, and Palau) (Fischer, 2002). The term "Pacific Islander" is a socially constructed, pan-ethnic classification that McFarlane describes as an identity label that "transcends national boundaries based on cultural backgrounds and similarity of experiences" (McFarlane, 2011). Ethnic identity is that aspect of social identity that derives from knowledge of membership in a social group and the value and emotional significance attached to that membership (Phinney, 1992). Ethnicity and race are often used interchangeably. Both terms identify social constructs used to categorize and characterize seemingly distinct populations. Ethnicity is self-declared and encompasses aspects of social life such as culture (cultural identity) and personal identity that people within collectives choose to share, distinct from racial designation (Airhihenbuwa, 2007). Ethnic groups are neither discrete nor homogeneous and often contain individuals with many ethnic affiliations (Dachs et al., 2008). Race is linked and assigned to phenotypes or physical characteristics such as skin color and ancestry that indexes one's location on the social hierarchy of socially constructed groupings (i.e., races) (i.e. races) (Ford & Harawa, 2010). The rich and complex identities of Pacific Islanders intersect the conditions of history, indigeneity, colonization, migration, culture, community, political and social systems, and geography. The expressions of ethnic identity have been heavily ascribed to the construction of race and racialization. Race and ethnicity have also been used in the collection and output of data in official statistics, particularly in measuring and monitoring health indicators and outcomes, which were explored in this study.

The global population of Pacific Islanders is estimated to be around 10 million people living across 25 nations and territories in Oceania (The World Bank, 2020). While many Pacific Islanders still live on or within their original islands, a large proportion of Pacific Islanders are living or have migrated to the larger settler societies such as Aotearoa New Zealand, Australia, and the U.S. Pacific Islanders represent a substantial and growing (Indigenous and diasporic) population in both Aotearoa New Zealand and the U.S. which is articulated as the geographic focus of this study (Stats NZ, 2017; U.S. Census Bureau, 2018).

The Native Hawaiians and Pacific Islanders (NHPI) in the United States

In the U.S., NHPIs make up less than one percent, 0.4 percent or 1.6 million people of the total U.S. population, according to 2019 U.S. Census Bureau estimates (U.S. Census Bureau, 2020). The term “Native Hawaiian” does not include individuals who are native to the state of Hawaiʻi by virtue of being born there, but rather are the Indigenous Kānaka Maoli/Kānaka ʻŌiwi or the aboriginal Polynesian peoples and their descendants of the Hawaiian Islands prior to European arrival. The other Pacific Islanders represent the peoples from the Pacific Islands other than Hawaiʻi or the Hawaiian Islands.

Due to its relatively small population, the body of nationally representative statistics for the NHPI population is limited. Historically, the U.S. categorized NHPIs with Asians under a single governmental classification, Asian Pacific Islander (Asian & Pacific Islander American Health Forum (APIAHF)). In 1997, the Office of Management and Budget (OMB) established separate racial categories, namely, “Asian” and “Native Hawaiian and other Pacific Islander (NHPI)” (Office of Management and Budget (OMB), 1997). Prior to this change, the paucity and lack of disaggregated data masked the identity and needs of both Asian and NHPI groups and severely hindered progress on vital issues such as health care access and health outcomes.

Western contact had disastrous consequences throughout Hawai’i’s history. Prior to western or pre-colonial contact from 500 A.D. to 1778, it was estimated that the Native Hawaiian population ranged from 150,000 to 1.5 million (Office of Hawaiian Affairs (OHA), 2017). The Native Hawaiian population increased by more than 200 percent from 1980 to 2010. Some of that growth, particularly from 1990 to 2000, can be attributed to the OMB changes to the racial data collection procedures. Enumerating the Native Hawaiian population alone is complex as many Native Hawaiians identify with multiple races or ethnicities. In the state of Hawaiʻi, Native Hawaiians are more than three times more likely to identify as multiracial, which can pose challenges not only in official statistics but also in representation in American political hegemony (Kamehameha Schools, 2014). The Pacific Islander groups also saw a population increase, especially those from the Micronesian groups such as the Marshallese and Chuukese (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014). The Chuukese population in 2010 was more than six times larger than reported in 2000, increasing from less than 700 to more than 4,000 (U.S. Census Bureau, 2018).

Native Hawaiians are the largest Pacific Islander subgroup in the U.S. They hold a unique position in that they are the only Pacific Islander subgroup whose islands were occupied and annexed by the U.S. and admitted as a state in 1959 (Baumhofer & Yamane). The other most significant Pacific Islander subgroups represented in the U.S. are Samoan and Chamorro/Guamanian. These groups also have historical ties to U.S. occupation, and both Samoa (American Samoa) and Guam became U.S. Territories. These three subgroups account for 74 percent of the respondents who reported belonging to a single NHPI group (Grieco, 2001). More than half of NHPIs live in the states of Hawai'i and California. Overall, most of the NHPI population is concentrated in the U.S. western region. The South and the Midwest regions have also seen a growth of NHPIs. While many NHPIs are born in the U.S., particularly in Hawai'i, many Pacific Islanders are U.S. nationals from U.S. territories such as Guam, American Samoa, and the Northern Mariana Islands. Many Pacific Islanders are also migrants from Pacific countries that entered into the Compact of Free Association (COFA) agreement with the U.S. (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014). These unique subgroup distinctions and migrant experiences have implications explored further in this study.

The Māori and Pacific peoples in Aotearoa New Zealand

In Aotearoa New Zealand, there is a clear distinction between its Indigenous peoples with a binary designation of Māori and its settler populations, non-Māori. The Māori are Polynesian and, therefore, culturally connected with other Polynesians and the whole Pacific (Somerville, 2012). Te Tiriti o Waitangi (Treaty of Waitangi) is the founding document that recognized the contractual relationship between two sovereign nations, the Māori as tāngata whenua (the first peoples of the land), and the British Crown or "the Crown" (colonizer) plays a critical role in defining Māori identity within the political context. The Treaty has produced numerous policies and practices that classify the Māori as a discrete ethnic or racial category (Chin et al., 2018; McCreanor & Nairn, 2002; Rata & Zubaran, 2016). The Māori are the second-largest racial/ethnic group in Aotearoa New Zealand, after the European group. Like the Native Hawaiians, the Māori population declined during its colonization period. The introduction of diseases and the land and tribal wars during the 1800s also contributed to the population decline that negatively impacted the Māori population (Kingi, 2007). The Māori population recovered and grew over time. In 2020, the Māori population grew 2.1 percent since its last census totaling about 850,500 or 16.7 percent of the total Aotearoa New Zealand population (Stats NZ, 2020b). Colonization and urban growth have led Māori to move (or be displaced) from their original tribal lands and into the urban areas (Ryks et al., 2014). Currently, 84 percent of Māori live in urban areas such as in the main metropolitan centers of Aotearoa in the cities of Auckland, Christchurch, Wellington, Hamilton, Tauranga, Dunedin, and Lower Hutt. Māori have a higher proportion of the population at 14.7 percent living in small urban areas and 18.0 percent in rural areas, compared with the total population at 10.0 percent living in small urban and 16.3 percent living in rural areas, respectively (Environmental Health Intelligence New Zealand (EHINZ), 2018b).

Pacific Islanders, or Pacific peoples identified according to the official New Zealand statistics, are a diverse population representing distinct cultures of many Pacific Islands. Some of the main Pacific ethnic groups represented in Aotearoa New Zealand, are from Samoa, the Cook Islands, Tonga, Niue, Fiji, Tokelau, Tuvalu, and Kiribati. For the purpose of comparing high-level ethnic groups in Aotearoa New Zealand, they are referred to collectively as Pacific peoples

(Ryan et al., 2019). Pacific peoples are the fourth largest racial/ethnic group in Aotearoa New Zealand, behind the Asian population ethnic group. Between 2013 and 2018, the Pacific population increased by about 3.4 percent and totaled about 407,700 or 8.1 percent of the total population (Stats NZ, 2019). Many Pacific Islanders are New Zealand-born or are migrants from the neighboring South Pacific. Aotearoa New Zealand has a long history of migration from the Pacific, as early as the 19th century. An influx of Pacific migrants arrived post-World War II as laborers looking for economic opportunities in New Zealand's growing and developing society. During the 1970s, the government clamped down on people overstaying their visas, mainly targeting Pacific Islanders (Fraenkel, 2012). Most Pacific peoples live in the major urban areas at 75.7 percent or larger urban areas at 11.6 percent (Environmental Health Intelligence New Zealand (Environmental Health Intelligence New Zealand (EHINZ), 2018b). The city of Auckland has the most significant urban concentration of Pacific Islanders in the Pacific Rim (Bedford, 1994).

While Native Hawaiians, Māori, and Pacific Islanders share a common Pacific heritage, it is important to acknowledge the diversity and the representations of the separate groups, each having its own cultural priorities and social constructions. The study analyses were rooted in the specific groups and geographic context as units of comparison. The use of race/ethnic identity-specific models captured both the unique differences and similarities within and across the Pacific communities.

Existing Cross-Country Comparative Literature, Aotearoa New Zealand, and the United States

Several studies exist comparing Indigenous populations' health experiences and disparities, particularly a cross-country comparison between Aotearoa New Zealand and the U.S.

A study conducted by Bramley et al., compared the health statuses of Māori and the American Indian/Alaska Natives of the U.S. Both Indigenous population groups revealed disparities across a range of health indicators, including health outcomes, use of preventive services, modifiable risk factors, and use of treatment services (Bramley et al., 2005). A paper by Chin et al., which served as an impetus for this study, compared Aotearoa New Zealand and the U.S. specifically in the approaches to health equity to inform policy efforts. The paper highlights issues for Indigenous peoples and racial/ethnic minority groups as they are more likely to experience disproportionate disadvantage than the general population. However, the experiences of specific groups were not discussed further in the literature. Chin et al. centralize the discussion around the healthcare systems of the respective countries, highlighting government and private policies impacting access to care, structure, quality of care, payment, and the integration of the countries' healthcare systems with social services. The paper concludes with how both Aotearoa New Zealand and the U.S. can commit to health equity (Chin et al., 2018). Other relevant literature reviewed was specific to the populations or country/regional context.

The Health Disparities and Inequities of Pacific Islanders

Indigenous people around the world and in the Pacific rim, such as the groups represented in this study, have a disturbingly similar pattern of health and social status. The unfortunate commonalities across the global Indigenous populations are persisting inequities in contrast with those of the dominant populations in their countries. Indigenous populations are known to suffer from lower life expectancy, high infant and child mortality, high maternal morbidity and mortality, heavy infectious disease loads, malnutrition, stunted growth, increasing levels of cardiovascular and other chronic diseases, substance abuse, and depression (Valeggia & Snodgrass, 2015). These disparities are not only in health status but across many determinants of health. The Social Determinants of Health (SDoH) has been the pervasive approach in public health to conceptualize the origins of these disparities. The SDoH model includes the socioeconomic, psychosocial risk factors, and structural and environmental characteristics that directly and indirectly impact the population's health status via lifestyle risk factors and access to or use of the health care system (Markwick et al., 2014). Some of the prevalent factors found in the Indigenous and also found among Pacific Islanders. These factors include but are not limited to poverty and socioeconomic disadvantage, lower educational attainment, lack of access and poor quality in health care and social services, poor housing conditions and homelessness, destruction of Indigenous economies and sociopolitical structures, incarceration, and the loss of lands and resources (United Nations Inter-Agency Support Group (IASG) on Indigenous Peoples' Issues, 2014). The following paragraphs highlight the available data and literature on pertinent disparities and inequities of key indicators among the NHPI in the U.S. and the Māori and Pacific peoples in Aotearoa New Zealand. Chapter 4 will include the examples of these indicators extracted from multiple publicly available data sources.

Native Hawaiian and other Pacific Islander Health in the United States

Life Expectancy

According to U.S. Projected Life Expectancy at Birth for 2015-2060, the life expectancy projections for NHPIs in 2020 was 80.8, 83.2 for NHPI females, and 78.5 for NPHI males. Non-Hispanic Whites were projected at 80.6, 82.7 for non-Hispanic White females, and 78.4 for non-Hispanic White males (U.S. Census Bureau, 2014). These projections create the assumption that NHPIs live longer. However, in a study conducted by Wu et al., the life expectancies of the major racial/ethnic groups in Hawai'i highlighted significant disparities. The study results showed the greatest life expectancy gap between the Native Hawaiians at 76.6 and Chinese

Americans at 87.8, according to life expectancy estimates in 2010. The disparities were partially explained by the differences in socioeconomic status, health behaviors, health access, and racism. Social indicators for Native Hawaiians were noted to have the lowest levels of educational attainment, lowest mean household income, and the highest prevalence of poverty of any group in Hawai'i (Wu et al., 2019). A resource from the Office of Minority Health reported that the life expectancies at birth for Pacific Islanders in U.S. jurisdiction (the U.S. States, Territories, and Associated States) were lower than the U.S. average at 76.1, Guam at 74.0 years, American Samoa at 71.6 years, Palau and Micronesia at 67.0 and Marshall Islands at 64.2 years (Palafox & Kaanoi, 2000).

Health Status and Behavior

There is a limited but growing base of literature documenting the health statuses of NHPIs. Multiple studies have reported a disproportionate share of health problems among NHPIs, compared with other demographic groups, including high rates of chronic health conditions such as high blood pressure, obesity, diabetes, and heart disease and mental health conditions such as depression and suicide (Blackwell et al., 2014; Grunbaum et al., 2000; Mau et al., 2009). Other studies have reported that compared to other ethnic groups, NHPI have disproportionately high rates of tobacco and other substance use, alcohol consumption, and obesity (Caraballo et al., 2006; Lew & Tanjasiri, 2003; Mukherjea et al., 2014; Subica et al., 2017; Subica et al., 2020). NHPIs also suffer disproportionately from cancer morbidity and mortality (Goggins & Wong, 2007). Cancer is one of the leading causes of death among NHPIs due to less access to cancer prevention and control programs (Tanjasiri & Peters, 2010). NHPI women are at higher risk for maternal morbidity and mortality. Analysis of data collected in Hawai'i found that 23 percent of the reported maternal deaths occurred in NHPI women, with half of the deaths deemed preventable from factors associated with mental health disorders and substance use (Maykin & Tsai, 2020). In 2020, NHPIs were one of the hardest-hit populations from COVID-19, the disease caused by severe acute respiratory syndrome coronavirus known as SARS-CoV-2. COVID-19 cases and death rates were higher among the NHPI populations in the U.S., especially in the states of California, Hawai'i, Oregon, Utah, and Washington (Kaholokula et al., 2020).

Socioeconomic Status

According to the U.S. Census, data from the American Community Survey (ACS) reported that 16.5 percent of NHPIs were living below the poverty level compared to 10.3 percent for non-Hispanic Whites. Detailed data reported higher poverty rates for the Samoan, Tongan, and Marshallese Pacific subgroups than the overall U.S. population's poverty rate (U.S. Census Bureau, 2019). In 2019, the average NHPI median household income was $66,695 compared to $71,664 for non-Hispanic white households (U.S. Department of Health and Human Services, 2021). The unemployment rate for NHPIs has been consistently above the rates of the total population for several years. In 2019, the unemployment rate for Native Hawaiians/Pacific Islanders was 5.9 percent, compared to 3.7 percent for non-Hispanic whites (U.S. Department of Health and Human Services, 2021). Educational attainment among NHPIs was reported lower than the national average. For example, in an ACS three year estimate data reported (2011–2013), the national bachelor's degree attainment rate was 29.1 percent, which was greater than the bachelor's degree attainment rate for Native Hawaiians at 20.5 percent, Guamanians/ Chamorros at 18.6 percent, Samoans at 13.4 percent, and Tongans at 12.3 percent (Teranishi et al., 2019).

Health Access and Utilization

NHPIs were less likely to be uninsured at 12.9 percent compared with adults in the total U.S. population at 16.3 percent. Among Pacific Islander detailed race groups, the percentages of those who were uninsured was 16.1 percent among Samoan, 15.1 percent among Guamanian or Chamorro, and 21.3 percent among other Pacific Islander adults, all of which were higher than the percentage among Native Hawaiian adults at 8.6 percent (Zelaya et al., 2017). NHPIs were more likely to be on government assistance programs such as Medicaid and Medicare compared to the Asian population and non-Hispanic Whites (Artiga & Orgera, 2019). The uninsured rates are higher among the subgroups of Pacific Islanders, such as those from Micronesia, the Marshall Islands, and the Republic of Palau. Under the COFA agreement, people from these islands have U.S. immigration privileges, but federal medical benefits are not always readily available to this population (McElfish et al., 2016). NHPIs were reported to have higher use of emergency care than other racial groups in California; reported from the California Health Interview Survey, 33.5 percent of NHPIs used emergency care compared to 19.9 percent for Whites (Tseng et al., 2010).

Social Well-being and Other Disparities

NHPIs are known to have families that live in large, multi-generational homes where health issues tend to be exacerbated by the issues described above, such as the lack of livable wages, food insecurity, and a lack of affordable housing (Look, 2013). In Hawai’i, households were three times more likely to experience overcrowding at 9 percent than the nationwide average of 3 percent. NHPIs are overrepresented among Hawai’i’s homeless. Data from 2016 reported that 42 percent of homeless individuals identified as NHPIs (Corey et al., 2017). NHPIs face multiple other stressors and are at elevated risk for mental illness, which can inhibit social and self-destructive behaviors, such as drug use, violence, and criminal activities, resulting in disproportionately high rates of arrest, incarceration, and interpersonal violence (Look, 2013). High levels of incarceration disproportionately affect NHPIs, which make up 40 to 60 percent of the prison population in Hawai’i and Arizona, which houses two private facilities specifically for inmates from Hawaii (Mahan-Laleleiki, 2017; Prison Policy Initiative, 2014).

Māori and Pacific people Health in Aotearoa New Zealand

In Aotearoa New Zealand, Māori health is of fundamental protective interest under the obligations outlined in the Treaty of Waitangi. It is a rash assumption that Māori would be in a better position regarding health. Māori have been documented to have the worse health status than non-Māori New Zealanders across almost all health indicators. Pacific peoples also exhibit similar health experiences. Both Māori and Pacific peoples are identified as priority groups by the government. They are more likely than the overall population or compared with other population groups to experience poor health outcomes and to have specific health needs (Ministry of Health NZ, 2001b). General contributing factors included poorer access to health services and poorer quality of care within the health system.

Life Expectancy

According to the Ministry of Health New Zealand, life expectancy among Māori has improved, although still lower than non-Māori on average, seven years less. In 2013, life expectancy at birth was 73.0 years for Māori males and 77.1 years for Māori females; it was 80.3 years for non-Māori males and 83.9 years for non-Māori females (Ministry of Health NZ, 2018). The life expectancy for Pacific peoples was lower than other ethnic groups excluding Māori, on average, five years. Based on death rates in New Zealand in 2012–14, life expectancy was 74.5 years for Pacific males and 78.7 years for Pacific females, compared with 79.5 years for males and 83.2 years for males in the total New Zealand population (Ministry of Health NZ, 2013).

Health Status and Behavior

Māori have much higher rates of smoking than non-Māori. For Māori, the impact of tobacco is significant. Cancer deaths related to tobacco use were higher among Māori (Robson & Harris, 2007). Cardiovascular disease (heart disease and stroke) death rates were two times higher for Māori than for non-Māori. Deaths due to respiratory disease were three times more frequent in Māori than in non-Māori (Robson & Harris, 2007). Māori are disproportionately represented among multiple cancers such as stomach, liver, pancreas, and lung, with poor survival rates accounting for 46 percent of Māori deaths compared to 27 percent in non-Māori (Ministry of Health NZ, 2016a). Mental health problems are significant issues among Māori. For example, 51 percent of Māori develop mental disorders such as anxiety, substance abuse, and mood disorder at some point in life. Rates of suicide attempts, and deaths are also higher among Māori (Baxter et al., 2006).

Pacific peoples also experience poorer health and more unmet need for health care than other groups. According to the Ministry of Health Survey, Pacific peoples have the highest rates of obesity, at 66 percent for adults (Pasefika Proud, 2016). Pacific adults also have higher rates of risky and poor health behaviors such as smoking, hazardous drinking, and lower physical activity than non-Pacific adults (Ministry of Health NZ, 2015). Mortality rates for cardiovascular disease and diabetes are higher among Pacific peoples in New Zealand than those for other ethnic groups (Ministry of Health NZ, 2013). In 2014, Pacific people reported a significantly higher prevalence of diabetes than all other ethnic groups at 10.5 percent, compared with 5.3 percent for Māori and European groups (Health Quality & Safety Commission New Zealand, 2014). Patterns of high mental health need and low service use have persisted for Pacific peoples. While Pacific peoples are more likely to experience mental distress than the total population, they are much less likely to have received treatment (Wells et al., 2006).

Socioeconomic Status

Historically, general socioeconomic outcomes for Māori and Pacific people have been less favorable than those for the European population in New Zealand. Aotearoa New Zealand does not have an official poverty measure. However, low-income thresholds or poverty lines can be used, such as a “fixed-line measure” that anchors the poverty line and 60 percent of the median income (Bellamy, 2011). In a Ministry of Social Development report, Māori and Pacific peoples typically have poverty rates around double those of the European group, regardless of the measure used. Poverty rates were reported at 23 percent of Māori, 22 percent of Pacific people, and 11 percent of European had household incomes below this threshold using the fixed-line measure (Perry, 2018). Another measure used is the Index of the New Zealand Deprivation (NZDep). The NZDep is an area-based measure used to describe the general socioeconomic deprivation experienced by groups of people in small areas of Aotearoa New Zealand. NZDep measures the lack of income, employment, communication, transport, social support, educational qualifications, homeownership, and living space (Tobias et al., 2008). Higher levels of socioeconomic deprivation are associated with worse health (Environmental Health Intelligence New Zealand (EHINZ), 2018a). In education, the 2018 Census reported that 80.6 percent of Māori and 83.0 percent of Pacific 15- to 24-year-olds had at least a level 1 qualification or equivalent (such as School Certificate), compared with 85.8 percent of 15- to 24-year-olds nationally (Stats NZ, 2018a). Other indicators reported unemployment rates at 8.3 percent for Māori and 8.0 percent for Pacific people compared to 3.7 percent for European (Stats NZ, 2021b). Pacific peoples in Aotearoa New Zealand have low homeownership rates at 28.8 percent compared with the average homeownership rate in the country, and the national rate was 56.8 percent. Māori homeownership was 39.1 percent (Grimes & Young, 2009). Housing overcrowding is also a socioeconomic indicator as it is associated with excessive costs of housing or difficulty securing housing. Māori have consistently lived in more crowded conditions than Europeans, and in recent years, Pacific peoples have experienced the highest levels of crowding (Stats NZ, 2018b).

Health Access and Utilization

Aotearoa New Zealand was one of the first countries to have a universal, tax-funded national health and integrated social service system. The system entitles all New Zealanders to have insurance that is government-funded and along with universally accessible health services (Goodyear-Smith & Ashton, 2019). Disparities persist even with insurance and access. As described above, Māori and Pacific peoples experience poor health outcomes, including access and utilization of health services. Key indicators include extensive wait times, cost of treatments, poor treatment experience, and lack of additional insurance coverage. Māori and Pacific people were less likely to report having private health insurance coverage than non-Māori and non-Pacific people. Individuals with private health insurance may have more timely access to non-urgent treatment than those without insurance. Those with higher incomes are more likely to purchase private insurance (Ministry of Health NZ, 2016b). Māori and Pacific adults were significantly less likely to see a primary health care provider than the adults in the general population. Māori and Pacific adults also reported that there had been inadequate time discussing their health with their health care providers. In New Zealand, the standard practice for a General Practice consult is 15 minutes. Language barriers and the lack of culturally competent practitioners contributed to poor health experiences with a care provider (Ryan et al., 2011).

Social Wellbeing and Other Disparities

There are numerous indicators from multiple population-based surveys that measure the health and wellbeing of New Zealanders. In the Social Report produced by the Ministry of Social Development, Māori and Pacific peoples performed less well across several social wellbeing measures, although improvements are occurring over time. For example, discrimination measures reported that Māori at 25.8 percent were more likely to be discriminated against than Pacific peoples at 19.9 percent and European/Other at 14.7 percent. Of those that had experienced discrimination, Pacific peoples were more likely than other ethnic groups to report being discriminated against in a public place or on the street at 47.6 percent, compared with 38.7 percent of Māori and 25.4 percent of those in the European/Other groups (Ministry of Social Development, 2016). In a study published in the New Zealand Medical Journal by Lee et al., Māori and Pacific peoples had the highest rates of depression and anxiety compared with other racial/ethnic groups. They were also less likely than those of other ethnic groups to receive treatment (Lee et al., 2017). Some of the identified barriers to treatment include stigma, cost, and cultural divides. Māori were also overrepresented in the criminal justice system, not only in Aotearoa New Zealand but also in Australia (Shepherd & Ilalio, 2015). Māori make up 52.8

percent of the New Zealand prison population compared to 11.5 percent for Pacific people and 30.5 percent for European (Department of Corrections, 2020).

Strategies in Reducing Disparities

Reducing disparities, especially among racial/ethnic groups, is a critical national priority for both the U.S. and Aotearoa New Zealand. In the U.S., the Affordable Care Act (ACA), also known as Patient Protection and Affordable Care Act which became law in 2010, required the U.S. Department of Health and Human Services to establish a National Quality Strategy as one of the many reforms introduced. The strategy includes a set of national aims and priorities to guide local, state, and national quality improvement efforts (Robert Wood Johnson Foundation, 2012). Multiple federal agencies are tasked with monitoring and reducing disparities, such as the Agency for Healthcare Research and Quality, the Office of Minority Health, the Health Resource and Services Administration, and the Indian Health Service (Commonwealth Fund, 2016). Accountability in health systems and health service delivery was also required through the ACA. Certain providers must report data on the quality of care and conduct and report a community health needs assessment. One of the significant components of the ACA was the attempt to expand coverage to address problems of affordability, health care quality, and efficiency and to strengthen primary and preventive care and public health that would, in turn, reduce disparities and improve equity. Artiga et al. and the Kaiser Family Foundation broadly investigated the effects of coverage expansions across multiple studies and how it has affected racial disparities in health coverage, access to care, health outcomes, and economic outcomes. Findings showed that the ACA narrowed gaps but did not eliminate disparities in health coverage (Artiga & Orgera, 2019; Guth et al., 2020). The ACA has improved insurance coverage but has not adequately reduced cost or improved quality. Ultimately, the U.S. still has not achieved universal health care (Glied, 2018). In other studies, the uninsured rate among NHPIs post-ACA, combined with the Asian American population group, showed a significant reduction. However, for aggregated NHPI subgroups alone, the reduction was not significant and may be due to a smaller sample size (Park et al., 2018). Other analyses have also observed slight increases in uninsured rates among the NHPI population for two consecutive years in 2017 and 2018 (Asian & Pacific Islander American Health Forum (APIAHF), 2019). Affording health care for all or a universal health care policy in the U.S. is perceived to be an arduous task to replace the current health system ravaged with disparities and inequities. There is evidence that improving coverage can improve access to care and contribute to improvements in health. However, it does not necessarily guarantee access to appropriate, high-quality health care. Coverage alone is not enough to eliminate disparities. Health disparities are complex and stem from many causal factors that need to be addressed within and outside the health sector.

In Aotearoa New Zealand, the government plays a significant role in establishing health care policies and service requirements. The government is the primary funder and supplier of health care and provides automatic coverage for all New Zealand citizens through public national insurance. No citizen can be denied treatment in public hospitals, and all citizens have insurance through government-funded, universally accessible health services. However, coverage varies by income, need, location, and type of service. Despite having universal coverage, health disparities are a major concern, especially among the Indigenous Māori and Pacific peoples. Several strategies have been enacted to mitigate the disparities among these priority populations. One example is the development of new models of Indigenous-led health care and the establishment of Primary Health Organizations (PHO), which is similar to the concept of Federally Qualified Health Centers (FQHC) in the U.S. The PHOs were established under the Primary Health Care

Strategy in 2001 that focused on population health, including health promotion and prevention, and the development of community-based services that would provide health care for priority populations, especially in hard-to-reach geographical areas (Ministry of Health NZ, 2001a). PHOs also extended services outside the traditional practice setting, such as in churches that acted as community centers for Pacific people and the marae, which are used as Māori community meeting houses but serve a much greater cultural purpose. These strategies have not effectively delivered their promises of health equity, especially for all Māori, Pacific people, or low-income populations (Goodyear-Smith & Ashton, 2019).

Racism as a Public Health Issue

There is an increasing recognition of the need to "dig deeper" and investigate the root causes of inequities and disparities. The National Academies of Sciences, Engineering, and Medicine (NASEM) identifies one of the main clusters and fundamental root causes of health inequity as "the unequal allocation of power and resources including goods, services, and societal attention which manifest in unequal social, economic, and environmental conditions, also called the social determinants of health" (Baciu et al., 2017). Racism is an umbrella concept that encompasses specific mechanisms that operate at the intrapersonal, interpersonal, institutional, and systemic levels of a socioecological framework (Jones, 2000). Gee and Ford suggest that studies of disparities should more seriously consider the multiple dimensions of racism as fundamental causes of health disparities, particularly structural racism (Gee & Ford, 2011). Structural racism is the most important and powerful way racism affects health (Williams et al., 2019). More explicitly, how structural racism underlies the persistence of health disparities and inequities among different minority groups. In his seminal work, W. E. B. Du Bois investigated the health disparities among Black and Whites in the U.S. and found that the disparities stemmed from social conditions such as racism and poverty and not from inherent racial traits (DuBois, 2003; Gee & Ford, 2011).

The connections between racism and health have been explained in self-reported experiences of discrimination or implicit biases based on race and the associations for adverse mental and physical health outcomes (Paradies, 2015). More research is emerging, and racism is now being explicitly recognized as a societal, systemic, structural, and, more so, declared a public health issue (American Public Health Association, 2020). Structural racism is defined as the macrolevel systems, social forces, institutions, ideologies, and processes that interact to generate and reinforce inequities among racial and ethnic groups (Powell, 2007). Preliminary analyses of large national datasets suggest that structural racism exists through the evidence of visible differences and persisting racial disparities. However, verification and understanding the scope of structural racism can only be done by explicitly learning and asking those affected about their lived experiences.

Pacific Islander Racism and Health

The experiences of racism have been heavily documented in the U.S., especially regarding the experiences of the Black/African Americans. However, little is known about the experiences of racism among Pacific Islanders. Structural racism is a largely unexamined barrier to a real movement towards health equity for Pacific Islanders.

Native Hawaiian and Pacific Islander Racism and Health

Of the available literature reviewed on structural racism, little focuses specifically on its effect on NHPI health. Morey et al., provides an overview of how structural racism has manifested during the COVID-19 pandemic, the 2020 decennial Census, and the 2020 Elections.

The article noted that NHPIs suffered disproportionately during the COVID-19 pandemic having high rates of cases and deaths compared to all other racial/ethnic groups in the U.S. The pandemic also created barriers for NHPI communities during the 2020 Census as the population group has been historically undercounted. Lastly, the paper explained voter disenfranchisement among NHPIs in which voting rights are limited for Pacific Islanders living in U.S. Territories and immigrants who have not gone through the naturalization process (Morey et al., 2020). In a chapter contribution, Baumhofer and Yamane focused on the nature of racism encountered and endured by the Native Hawaiians and how it affects their health and wellbeing at the institutional, interpersonal, and internalized levels. Institutional racism has affected Native Hawaiians by dismantling Native Hawaiian cultural practices in favor of Western ones. The loss of land, culture, and traditions has had a negative impact on the health of Native Hawaiians. Historical trauma was identified as a type of institutional racism in which the effect of traumatic historical events is transferred through multiple generations contributing to poor health outcomes (Baumhofer & Yamane; Evans-Campbell, 2008). NHPIs in the U.S. are vividly diverse, and a common theme in the literature surveyed is the need for more context to understand the nuances of the NHPI experience. There is a need to explicitly explore the processes and manifestations of structural racism and its effects on NHPI health.

Māori and Pacific People Racism and Health

In Aotearoa New Zealand, the literature on the experiences of racism, specifically its associations with Māori and Pacific people health, was much more available. There is a long-standing body of research and a large and growing research base examining the experiences of racism and potential impacts on health by ethnicity (Barnes et al., 2013; Huria et al., 2014;

Mayeda et al., 2014). Research has documented experiences of racial discrimination against Māori and other minority groups such as Pacific peoples in a range of settings, such as in education, housing, policy and legislation, health and the healthcare system, policing, and in the media (Brittain & Tuffin, 2017; Cormack et al., 2020; Harris et al., 2012; Harris et al., 2018; Houkamau & Sibley, 2015; Loto et al., 2006; Mayeda et al., 2014; Nairn et al., 2006). A strength of the Aotearoa New Zealand-based studies has been the focus on inequity analyses, which center Māori and often conceptualize racism as a determinant of health within the context of the enduring and harmful impacts of colonization (Talamaivao et al., 2020). Another strength of Aotearoa New Zealand is that the national surveys such as the New Zealand Health Survey and the General Social Survey have included measures to address the experiences of racial/ethnic discrimination, acknowledging the significance of racism as a determinant of health social wellbeing indicator. However, the surveys cannot fully capture the effects of structural racism. Structural discrimination and racism have been acknowledged in Aotearoa New Zealand, primarily through its colonial legacy and its injustices towards the Indigenous Māori. In a 1988 report of the Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, symptoms of structural imbalances in Aotearoa New Zealand were found in "unemployment, poor housing, street kids, young offenders, homelessness dropouts, child abuse, alienation, family disruption, low incomes, low self-esteem, and lack of opportunity (New Zealand. Ministerial Advisory Committee on a Maori Perspective for the Department of Social, 1986). Although there is compelling evidence of racism in Aotearoa New Zealand, the persisting inequities are indicators of the need for an improved strategy to address the structural elements of racism effectively. The following section will explore some of the theoretical concepts and frameworks that guided this exploratory study.

Theoretical Concepts and Frameworks

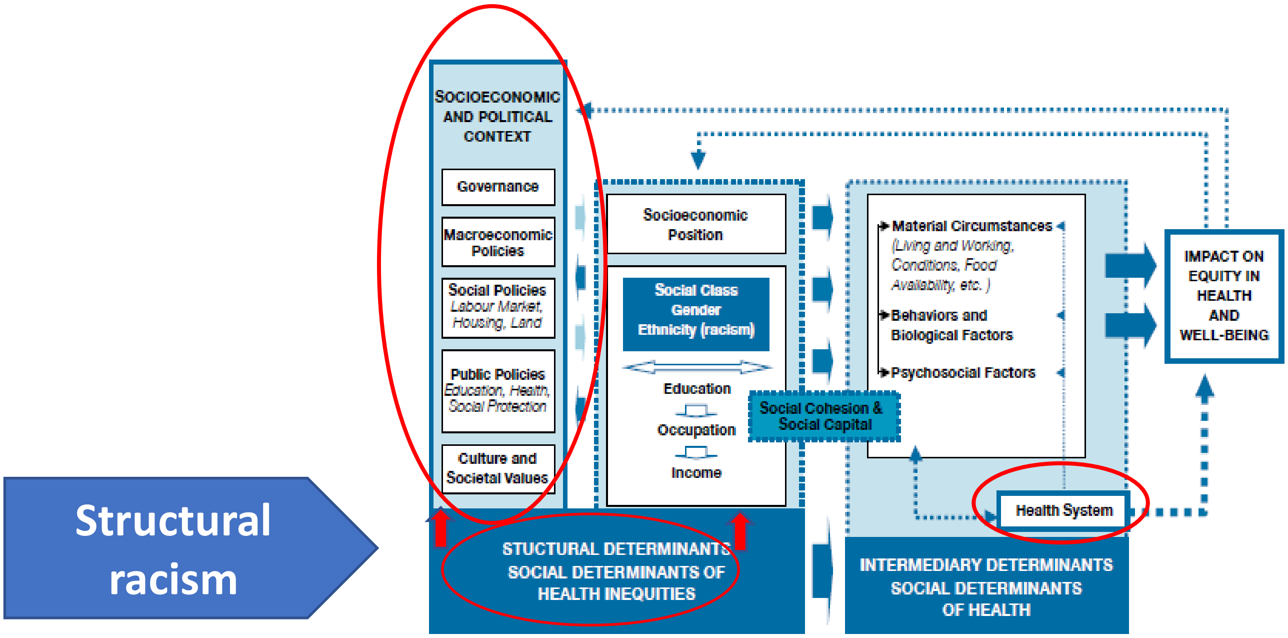
This study was guided by the concepts and frameworks described in this section to explore how structural racism underlies the persistence of health disparities and inequities among Pacific Islanders.

Social Determinants of Health

According to the World Health Organization, the Social Determinants of Health are described as the non-medical factors that influence health outcomes. These are the conditions people are born into, grow up with live in, and age with, and the broader set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems (World Health Organization, 2017). The WHO Commission on Social Determinants of Health Framework provides an applied illustration of how a force, specifically structural racism, can affect the socioeconomic and political context and impacts the social determinants of health, leading to a cascade of health inequities. It was used as the guiding framework for this study. The framework was also used to identify measures of interest, including health status and outcomes, health systems factors, the physical environment, socioeconomic factors, and demographics. It was also used to identify the parameters of public health practice, which helped identify key areas that are impactful in addressing health disparities.

Figure 1.

A conceptual framework for action on the social determinants of health (Solar & Irwin, 2010)



Structural Theory of Racism

The following framework is the work of Sociologist Eduardo Bonilla-Silva who developed a contemporary approach to studying race towards a structural interpretation. In his 1997 paper, Bonilla-Silva challenges the view of racism “as purely an ideological phenomenon.” Bonilla-Silva describes racism as a “racial ideology of a racialized social system,” this implies that racism is only part of the larger racial system. He offers the alternative perspective, contending to ground racism in a “racial structure” or a “racialized social system” (Bonilla-Silva, 1997). Racism is a pervasive phenomenon that negatively impacts certain groups even in the absence of explicitly perceived or reported acts of racism. The individual-level “acts” of racism rarely operate in isolation. They are driven, often unthinkingly, by ideologies of racial superiority and inferiority and produce a self-replicating, hierarchical system of disadvantage and oppression for subordinated populations. A structural racism framework supports the conceptions of racism focused on individual-level prejudices and widens the scope of examining how multiple institutions interact to reinforce and reproduce inequities between racial/ethnic groups, such as racialized disparities in areas such as health and socioeconomic status (Bonilla-Silva, 1997; Carty et al.). Bonilla-Silva concluded his paper in which he stated, "to test the usefulness of racialization as a theoretical basis for research, we must perform comparative work on racialization in various societies" (Bonilla-Silva, 1997). This statement encourages the application of his framework for the study to compare and examine the specific mechanisms, practices, and social relations that produce and reproduce racial inequity formed through racialized structures in the U.S. and Aotearoa New Zealand.

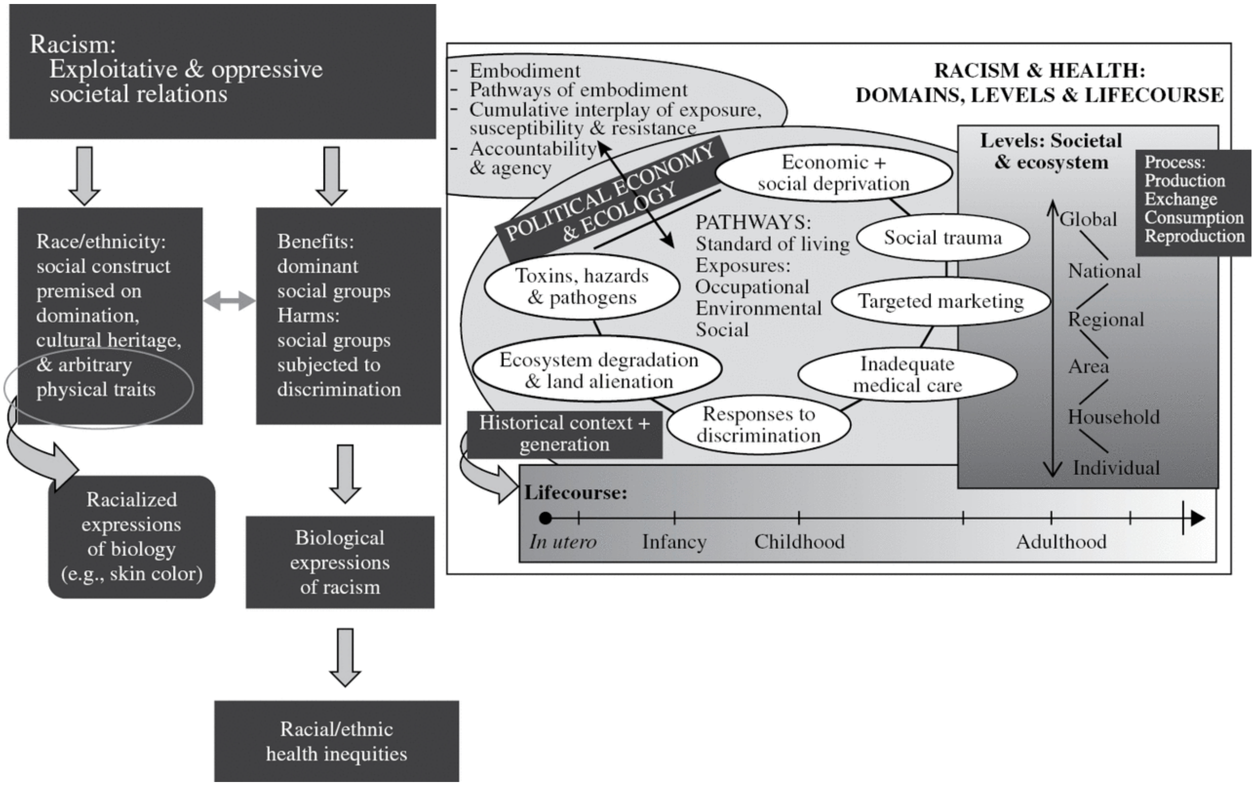
Ecosocial Theory

The next theoretical concept is from the work of Social Epidemiologist Nancy Krieger. Krieger introduces a multilevel epidemiological framework that seeks "to integrate social and biological reasoning and a dynamic, historical, and ecological perspective to develop new insights into determinants of the population distribution of disease and social inequities in health. (Krieger, 1999, 2012)." Krieger draws on Ecosocial theory using the central question of "who and what is responsible for the population patterns of health, disease, and wellbeing as manifested in past, present, and changing social inequalities in health (Krieger, 2005). In application, the theory frames and guides the analysis of the phenomenon, given the example of population distributions of health, disease, and wellbeing, to generate knowledge relevant to altering the phenomenon under study, such as the existence of health inequities (Krieger, 2011). here are five core constructs outlined below. Figure 1 is the Ecosocial Theory schematic illustration applied to analyzing the embodiment of racial inequality and its implications for health inequities.

1. Embodiment: refers to how we incorporate, biologically, in a societal and ecological context, the material and social world in which we live.
2. Pathways of embodiment: via diverse, concurrent, and interacting pathways involving adverse exposure to social and economic deprivation, exogenous hazards (e.g., toxic substances, pathogens, and hazardous conditions), social trauma (e.g., discrimination and other forms of mental, physical, and sexual trauma), targeted marketing of harmful commodities (e.g., tobacco, alcohol, other licit and illicit drugs), inadequate or degrading health care; and degradation of ecosystems, including as linked to alienation of Indigenous populations from their lands.
3. The cumulative interplay of exposure, susceptibility, and resistance across the life course refers to the importance of timing and accumulation of, plus responses to, embodied exposures involving gene expression, not simply gene frequency.
4. Accountability and agency: both for social disparities in health and research to explain these inequities.

Figure 2.

Ecosocial analysis of racism and health: core concepts and pathways of embodiment (Krieger, 1999, 2011).

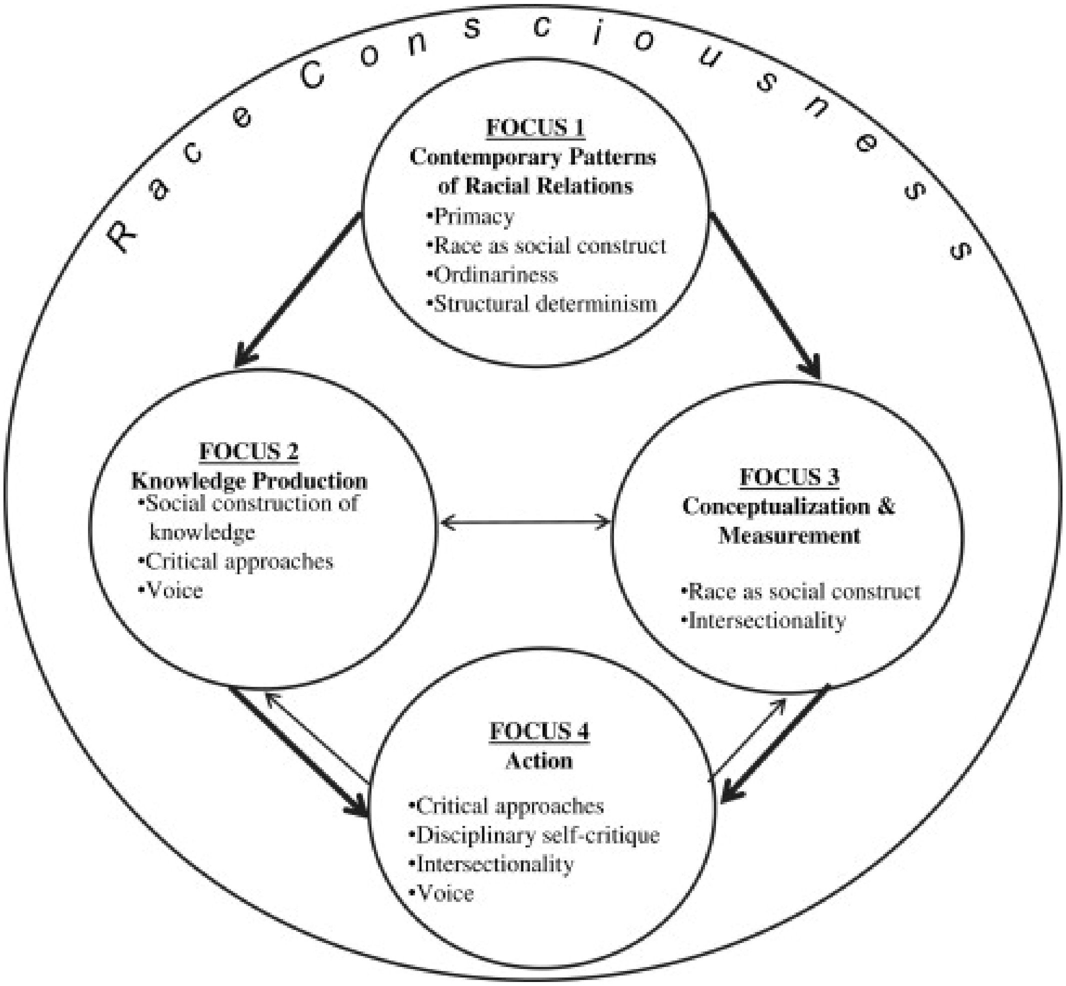


Critical Race Theory

The next theoretical framework explored is Critical Race Theory (CRT), which inspired an iterative methodological approach for the study. CRT originated in legal scholarship, is grounded in social justice, and has been adopted by fields such as education and ethnic studies as an approach to investigate, understand, and eliminate various inequities accentuated by the constructed and discursive nature of race. CRT is a tool for scholars as a means to understand and challenge racism. CRT utilizes a framework that targets the subtle and systemic ways racism operates beyond the overt expression of racism (Crenshaw et al., 1995). Delgado and Stefancic discuss some of the principles of CRT that include the critique of liberalism, storytelling, structural determinism, intersectionality (race, class, and gender), essentialism and antiessentialism, cultural nationalism/separatism, and critical pedagogy (Delgado & Stefancic, 2017). In research, the use of CRT implies that the investigator foregrounds race and racism in all facets of the research process and confronts conventional research texts and worldviews (Creswell 2007). The application of CRT has been adapted for practical application in public health and health equity research by Chandra Ford and Collins Airhihenbuwa, namely Public Health Critical Race Praxis (PHCR). Ford et al., has demonstrated a practical application of PHCR as a tailored approach to CRT to inform a study of racism and HIV testing among African Americans (Ford et al., 2018). PHCR uses the tenets of CRT for conducting research and practice within community-based research and is intended to expose contemporary racial phenomena and explicitly integrate the knowledge of the racial/ethnic minority communities by centering their perspectives in the examination and production of empirical research (Ford & Airhihenbuwa, 2010). There are four main phases to the PHCR research process: Focus 1 is the contemporary patterns of racial relations, Focus 2 is knowledge production, Focus 3 is conceptualization and measurement, and Focus 4 is action. Figure 2 provides a visual schematic of PHCR intended to be used as a roadmap to guide researchers in the process. The application of CRT and PHCR in this study provided the potential to take an exploratory and critical approach in grounding the research on the perspectives of Indigenous and Pacific Islander identities, further rationale of the application of several elements of CRT, and PHCR will be discussed in the next chapter.

Figure 3.

Public Health Critical Race Praxis schematic, Race consciousness, the four focuses and ten affiliated principles (Ford & Airhihenbuwa, 2010)



Summary

A comparative case study analysis between New Zealand and the U.S. offers a unique understanding of the health experiences of Pacific Islanders. Health disparities and inequities are heavily prevalent in the reviewed literature, with multiple explanations for their causes. Both countries share fundamental characteristics as developed, western democracies with health systems aimed at prioritizing reducing and eliminating racial/ethnic disparities. New Zealand and the U.S. also have experienced navigating through the rippling effects of colonialism and racism and the associated adverse health consequences that are sharply divided along racial/ethnic lines (Chin et al., 2018). There is a need to understand further the potential causes of health disparities, such as the effect of racism. There is a growing interest to focus on racism as a fundamental cause and driver of poor health. More specifically, the focus on racism that is not always explicit or readily visible and rather the racism that is implicit, systemic, and structural. The findings of this study offer new insights into a more comprehensive historical and socio-political understanding of how structural racism affects Pacific Islanders and their complex and intersecting identities. Guided by the theoretical concepts and frameworks described above, this study described the ways racism is operationalized through structures and public health practices in New Zealand and the U.S. and how they are perceived to impact Pacific Islander health.

CHAPTER 3: Methodology/Approach

In this study, a critical lens was warranted to explore the possible explanations of the causes of persisting health disparities and inequities among Pacific Islanders. Assessing the potential causal factors such as those that make up the social determinants of health is a complex approach. These factors exist at different organizational levels, which need to be appropriately conceptualized and measured. The dynamic of these factors tends to produce racially unequal outcomes governed by structural forces such as policies, culture, and societal values. Under the lens of structural racism, the study explored and contextualized the contemporary disparities and inequities as partly derivative from past norms and conditions that have been operationalized and persisted through time. Exploring the relationship between structural racism and health in the Pacific Islander experience is broadly understudied. Identifying and illuminating the causes and remedies for Pacific Islander disparities and inequities required the integration of findings using multiple methodologies.

The purpose of this study was to examine the extent to which structural racism explains the cause of the persistent disparities and inequities in health experienced by Pacific Islanders in the United States (U.S.) and Aotearoa New Zealand. The research questions that guided the investigation are presented below.

1. Does the available data identify a pattern of racial disparities and inequities for Native Hawaiian and Pacific Islanders in the U.S. and Māori and Pacific Islanders in Aotearoa New Zealand?
2. How does the community perceive the cause of disparities and inequities?

3. What is the way forward to improving Indigenous Pacific Islander health and social outcomes and health equity?

Study Aims

The study had two aims to answer the research questions above:

Aim 1: To identify health and social indicator outcome measures and assess for pattern(s) of racial disparities and inequities among Native Hawaiian and Pacific Islanders in the U.S. and Māori and Pacific Islanders in Aotearoa New Zealand. This aim utilized quantitative and qualitative methods to answer the first research question.

Aim 2a: To describe the cause of racial disparities and inequities among Native Hawaiian and Pacific Islanders in the U.S. and Māori and Pacific Islanders in Aotearoa New Zealand. This aim primarily used qualitative methods to answer the second research question.

Aim 2b: To explore the way forward with lessons learned and recommendations to improving Indigenous Pacific Islander health and social outcomes and health equity. This aim primarily used qualitative methods to answer the third research question.

Research Methodology, Study Design and Sample

This study was designed as an exploratory comparative case study, employing mixed methods to examine the degree to which disparities and inequities in health and social status of Pacific Islanders in the U.S. and Aotearoa New Zealand may result from structural racism. Exploratory case studies aim to answer the questions of "how," "what," and "why" to explore a phenomenon in context using one or more data collection methods. Yin presents a case study as "an empirical inquiry about a contemporary phenomenon, set within its real-world context—especially when the boundaries between phenomenon and context are not evident (Yin, 2017). A case study approach is most appropriate if the potential exists for contextual conditions to be "highly pertinent to the phenomenon of study" (Yin, 2017). The identified rationale was the persistence of racial disparities among Pacific Islanders in the U.S. and New Zealand. The exploratory nature of the study design is characterized by the limited understanding of the relationship between structural racism and Pacific Islander health disparities, with the opportunity to explore the phenomenon with varying levels of depth.

In the interest of exploring structural racism among Pacific Islanders in the two geographical contexts of the U.S. and Aotearoa New Zealand, a comparative element was utilized in the study design. A comparative case study examines "in rich detail the context and features of two or more instances of a specific phenomenon" (Mills et al., 2010). Mixed methods research is "research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program of inquiry" (Tashakkori, 2007). Qualitative and quantitative data and methods were used in this study. The sequence of the study design followed a concurrent triangulation in which the collection of quantitative and qualitative data was conducted at the same time. This type of sequence aims to validate the findings generated by each method through evidence produced by the other (Tashakkori, 2007). The results were merged or triangulated, and the researcher interpreted any data convergence, divergence, contradictions, or any relationship that the separate data analyses revealed. Like most exploratory studies, this study was qualitative to observe evidence of structural racism through the quantified measures of racial disparities.

Case Selection Rationale

The interest to examine the disparities and inequities among the Native Hawaiians and Pacific Islanders in the U.S and the Indigenous Māori and Pacific people of New Zealand was inherently based on the shared genealogy and culture of the ancient Pacific way finders who have migrated and settled on islands across Oceania in which transformed their ancient island-nations into contemporary globalized and settler societies of the U.S. and New Zealand. There are distinct differences among the Pacific Islander groups beyond their pan-ethnic identity and geographies. Other similarities are found within the historical and political contexts. These groups are similar in that their Indigenous identities and lands have historically been colonized. These groups are smaller compared to other race/ethnic groups and are considered the racial/ethnic minorities in their respective countries. They are also prioritized public health populations as groups that bear the burden of poor health and socioeconomic outcomes (Agency for Healthcare Research and Quality, 2019; Health Research Council New Zealand). For the purpose of this study, the groups were occasionally identified collectively again as Pacific Islanders/Indigenous Pacific Islanders when appropriate.

Instruments

Quantitative data was collected from a combination of secondary data and grey literature. Examples include previous/relevant studies, government publications, periodic reports, white papers, policy documents, conference proceedings, private sector papers, publicly available data from national repositories, and surveillance surveys conducted in the U.S. and New Zealand. Table 2 below are a few examples of data sources that were utilized to achieve the objectives of Aim 1. Qualitative data were also obtained from the secondary data of the grey literature, as well as the key informant interviews to achieve the objectives of Aim 2.

Table 1.

Examples of Publicly Available Data Sources from United States and Aotearoa New Zealand.

United States		New Zealand	
Data	Source	Data	Source
National Health Interview Survey (2014)	Center for Disease Control and Prevention	New Zealand Health Survey (Multiple years, 2018/2019)	Statistics New Zealand, Ministry of Health
Hawaii Behavioral Risk Factor Surveillance System (BRFSS) (2018)	Hawaii Health Data Warehouse, Hawaii Indicator Based Information System	New Zealand General Social Survey (2018)	Statistics New Zealand
National Health and Nutrition Examination Survey (NHANES) (Multiple years, 2011-2014)	Center for Disease Control and Prevention		

Research Procedures and Data Analysis

At the onset of the study, a foundational synthesis of prior literature, presented in the previous chapter, identified gaps in the knowledge base, systemized the application of theory and concepts and methodology, and described the implications and directions of the research. The study attempted to apply the principles of public health critical race praxis (PHCR) grounded in critical race theory (CRT). The methodology is framed by race consciousness in society and one's life. It encompasses four focus areas in the PHCR research process: (1) contemporary patterns of racial relations, (2) knowledge production, (3) conceptualization and measurement, and (4) action (Ford & Airhihenbuwa, 2010). According to Ford and Airhihenbuwa, understanding the causes of racial health inequities "requires a solid understanding of the salience of racialization in society and one's personal life; therefore, race consciousness frames the whole research process” (Ford & Airhihenbuwa, 2010). Race consciousness was imperative to the research process as the study engages the perspectives of Indigenous Pacific Islander identities. The researcher and research required consistent reflection on personal connection to the work, race consciousness, worldviews, and responsibilities to ensure respectful research relations and accountability in the produced knowledge and reports.

Aim 1: Document Review

A document review was conducted to achieve Aim 1 by gathering and selecting relevant documents from the sources mentioned in Table 1 above. A document review, also called a document analysis, has been commonly used as a methodology in health policy. Formal, written documents are important as a key characteristic of the bureaucracies by which modern societies function, including public health (Dalglish et al., 2020; Waters, 2015). Bowen describes document analysis as a form of qualitative research in which the researcher interprets documents to give voice and meaning around an assessment topic (Bowen, 2009). Documents were first superficially skimmed for relevancy to the study topics and, if they met criteria, were thoroughly examined through an iterative process of content and thematic analyses. O’Leary describes the technique of noting occurrences, or content analysis, “where the researcher quantifies the use of particular words, phrases, and concepts” (O’Leary, 2014). The documents provided background information, historical context, supplementary data, resource leads, and suggestions for additional research questions. The data collected was analyzed to identify and characterize important aspects of the processes such as historical context, constraints, relationships, and the mechanisms that drive Pacific Islander health disparities and inequities. Document analyses also helped identify specific indicators/measures; examples are presented in Table 2 below.

Table 2.

Examples of Indicators and Measures Utilized to Examine Health Disparities

Domain/Category	Subdomain	Indicators/measures
Health Outcomes	Quality of life	Life expectancy at birth Infant mortality rates Maternal mortality rates Health behavior (smoking, alcohol use) Morbidity or Co-morbidity (cancer, heart disease, diabetes, obesity) Psychological distress Stress Discrimination
Health Factors	Health behavior	Tobacco Use
	Diet and exercise	Food insecurity Obesity Physical inactivity
	Alcohol and drug use	Excessive drinking Substance use
Healthcare	Access to care	Insurance/uninsured Primary care physicians Mental health providers
	Quality of care	Preventative hospital states Cancer screening rates Vaccination rates
Social and Economic Factors	Education	Education level/high school graduation College
	Employment	Unemployment
	Income	Median household income Income inequality Poverty Social Welfare Benefit (NZ) Free/reduced lunch eligibility
	Family and Social Support	Single-parent household Residential segregation (white/non-white)
	Community Safety	Suicide rates Homicide rates Incarceration rates
Physical Environment	Housing and Transit	Homeownership Severe housing cost burden Homelessness
Demographics	Race/Ethnicity	Native Hawaiian/Pacific Islander (US) Māori (NZ) Non-Māori (NZ)

		Pacific Islander (NZ) Comparison against overall, White, European groups
	Sex	Male/Female
	Age	Adult age structure (NZ): 18 to 24, 24 to 44, 45 to 64 65 years and over Adult age structure (NZ): 15 to 64 65 years and over

The document analysis included both quantitative and qualitative components. The quantitative components included select indicators that were assessed as presented in Table 2 to illustrate quantified indices and identify disparities by looking for disproportionate patterns and racial differences comparing Pacific Islanders with White/European groups and or the general population. In this study, the impacts of structural racism were evaluated by matching observed health disparities to racialized differences in exposure to spectra of structural racism (Groos et al., 2018).

Secondary data from publicly available sources or sourced from the grey literature were extracted and presented as complete counts or censuses. The use of secondary data analysis is beneficial because it is cost and time effective since the data collection has been executed and vetted by qualified agents. Moreover, the data collection limitations are reported, particularly concerning publicly available data from government data repositories.

The analysis also included elements of comparative cross-national approaches. Elder defines comparative cross-national methodology as “an approach to knowing social reality through the examination for similarities and differences between data gathered from more than one nation (i.e., a people organized under a common government, that government having a monopoly of legitimate physical coercive force within a given territory)" (Elder, 1976).

Data were assessed in their original, local context and compared internally to form exclusive profile cases for the U.S. and New Zealand**.** General comparisons and contrasts were used to describe and explain similarities and differences (or even uniqueness) to develop limited cross-national generalizations. Findings from across the two country profiles and the documents were synthesized.

Aim 2: Key Informant Interviews

To achieve the Aim 2, 27 key informant interviews were conducted between September 2021 and February 2022 using a combination of purposive and snowball sampling techniques. Key informant interviews are qualitative in-depth interviews that are especially beneficial for an initial assessment of an organization or community issue, allowing for a broad, informative overview of the issues (Lavrakas, 2008). The purpose of key informant interviews was to collect information from a wide range of people—including community leaders and professionals—who have first-hand knowledge of the community. These informants are considered community experts who have the particular knowledge and understanding to provide valuable insights into the nature of problems and provide recommendations for solutions (UCLA Center for Health Policy Research, 2004). In the application of CRT and PHCR Praxis, the perspectives of the key informants recognize the experiential knowledge of the Indigenous Pacific Islanders and were centered and viewed as informational knowledge stemming directly from their lived experiences (Bell, 1992; Delgado & Stefancic, 2017).

Participant recruitment. Potential key informants were identified guided by social determinants of health to represent (but are not limited to) the following sectors: private and public sector business, community and human services, criminal justice, education, emergency services, faith, government, law enforcement, media, medical/health services, mental/behavioral health, philanthropy, and transportation. Key Informants were selected if they had at least five years of leadership and/or work experience and were over 18. Key informants also identified if they had five years of experience working with the Indigenous and Pacific Islander populations within the scope of public health in the U.S. or Aotearoa New Zealand. Participants were excluded if they were under the age of 18 and if they refused to give informed consent. The study and interview protocols were reviewed and approved by the Claremont Graduate University Institutional Review Board Committee.

Email was used as the method of recruitment for key informant interview participants. Cold introduction emails were sent out to prospective participants. The introductory email provided information on the study purpose, participation requirements, including participating in a 50-90 interview, compensation, and the researcher’s contact information. Interview participants were also asked if they could recommend anyone of similar status or position that they think would be interested in participating in an interview by forwarding the recruitment email and the researcher’s contact information. See Appendix A. Recruitment Emails for recruitment materials. This method was used to protect the confidentiality of the participant and lessen the coercion of additional participants in this study. Interested participants who responded to the initial email were then sent a follow-up email that included a link to an online scheduling platform to schedule an appropriate date and time for the interview. The scheduling platform allowed the participant to see available interview dates and times based on the availability of the researcher in their respective time zones and to minimize scheduling confusion. An automated email from the scheduling platform populated a calendar invite of the participant's selected date.

A confirmation email was also sent to the participant to provide them with the informed consent and a link to a demographic questionnaire. Both items were requested prior to the scheduled interview session. A signed copy of the informed consent form fixed with the researcher's signature was sent to the participant for their records. Participants were sent a reminder email at least 24 hours before the scheduled interview session. See Appendix B for the Copy of the IRB-approved Informed Consent and Demographic Questionnaire. The demographic questionnaire was a survey of 25 items which included demographics, questions about structural racism, health equity, and disparities.

Data collection. Interview protocols were developed over the course of Aim 1 as the findings from that aim assisted in conceptualizing specific guiding and probing questions that explore the relationship between structural racism and Pacific Islander health. See Appendix C for Interview Protocols and Guide. The use of an interview guide allowed the interviewer to freely explore, probe, and ask questions that elucidated and illuminated the particular subject of discussion (Patton, 2005). During the interview, before the formal questions, the researcher communicated the rules and protocol of the interview, and verbal consent was obtained prior to the start of the interview session as interviews were recorded for transcriptions and analyses. The researcher grounded the session and participant to begin the interview, beginning with a cultural exchange of introductions. For example, it is customary in Māori culture – also in Native Hawaiian and Pacific cultures to present an acknowledgment of whakapapa (te Reo Māori) or moʻokūauhau (ʻōlelo Hawai'i), who and where they come from or their genealogy. Not all interviews included a genealogical introduction. The space was granted to the participant to express and introduce themselves as pleased, especially expressions in their Native language. After the introductions, the formal interview started with the first section in which participants were asked to share their work and professional experience as it relates to public health and working with Pacific Islander populations which include but are not limited to those who are from Polynesia (e.g., Hawai’i, Tonga, Samoa, and Aotearoa New Zealand), Melanesia (e.g., Fiji and Vanuatu), and Micronesia (e.g., the Marshall Islands, the Federated States of Micronesia, Guam, and Palau). The following interview questions explored participants’ perceptions of Pacific Islander health disparities and ways to improve health outcomes and equity for these communities.

The formal interview was divided into four parts with questions on the following, Part 1 was on their community work, professional and leadership experience, as mentioned in the previous paragraph. Part 2 focused on Pacific Islander health and health disparities. Example open-ended questions included how they perceived the health status and quality of Pacific Islanders and were asked if they could identify the most critical issues and disparities related to Pacific Islander health. Part 3 focused on structural racism. Example questions included whether they believed structural racism exists among Pacific Islanders and how racism came to be by exploring history, culture, and policies. Participants were asked if they could provide examples of ways racism is manifested and how it impacts Pacific Islander health and wellbeing. Lastly, part 4 focused on health equity. Participants were asked to share ways to improve Pacific Islander health, their thoughts and perceptions on leadership, and their vision of advancing health equity for Pacific Islanders. If the participant stated that their work and experience is with a particular population, such as Māori, Native Hawaiian, or Indigenous populations, the questions specifically identified those communities.

Initially, the study was set up to be conducted in person when possible. Approval was permitted from the Institutional Review Committee. However, due to the ongoing situation with COVID-19 and the impeding restrictions on gathering and traveling, all key informant interviews were taken place virtually over a virtual meeting platform, Zoom. Interviews were scheduled for an hour and a half and ranged from 50 to 90 minutes, with extra time cushioned to allow more time to speak and debrief as needed. After each interview was conducted, interviews were automatically transcribed, which was enabled from the Zoom recording. The recordings did not capture accurate verbatim, and transcripts were reviewed for accuracy and removal of any identifying information by the researcher. Interview transcriptions were typed out on a Microsoft Word document. The researcher verified transcriptions with the participants to ensure the accuracy of terms used in language and fill any gaps in the recorded discussions. Interview transcripts were uploaded to NVivo, a computer software program used for qualitative research and analysis.

Data analysis. Analysis of the key informant interview data followed similar methods used in the document analyses. Data was sorted, coded, and compared using grounded theory (Corbin & Strauss, 2014). A thematic analysis was used to examine the interview responses to identify common themes, patterns, and relationships related to the topic(s) of discussion and the overall research. A theme is defined as a coherent integration of the disparate pieces of data that constitute the findings (Sandelowski & Leeman, 2012). Identified and emerging themes may be grouped into larger themes (Charmaz, 2006). A codebook was produced to assist in the coding, and sorting process managed using NVivo software. Organized codes help identify patterns and connections within and between categories. While common themes are important, attention to the themes that do not fit the categorized patterns may be of some value to the analysis to inquire further on what the contrasting ideas suggest. A thematic analysis was conducted to identify common themes, patterns, and relationships related to the research aims and questions.

Final Analysis and Reporting

The data collected for Aims 1 and 2 were synthesized by triangulating the findings. Aim 1 primarily employed data triangulation within as the document review applied the synthesis of multiple, diverse sources of qualitative and quantitative data. The final analysis examined the multiple data sources, quantitative and qualitative to validate results, and built a detailed understanding of the findings (O'Donoghue & Punch, 2003). The results in Chapter Four and the discussion in Chapter Five are written in narrative form and are primarily concerned with providing the reader with insight and understanding of unique cases or situations. According to Stake, qualitative research tries to establish “an empathetic understanding for the reader, through description, sometimes thick description, conveying to the reader what the experience itself would convey” (Stake, 1995). Specific extracted examples of the analysis that are vivid and compelling were used to produce the narratives in the final two chapters. Findings addressed the research questions and literature in ways that enhanced the understanding of the contextual factors and provided a means for transmitting practical knowledge with recommendations and lessons learned.

Ethical Considerations

Due to the nature of the content and sensitivity of the potential discussion topics, interview protocols were developed to ensure the participants’ informed consent, safety, and confidentiality were protected throughout the study. Consent was obtained from participants before they participated in the interview. Key informant interview participants were informed that their identities (e.g., name, place of work, etc.) would be kept confidential. A recording of the interview and any relevant files were secured on a password-protected computer. No identifiable information will be provided in the publication of the study. If necessary, participants may be identified utilizing an alias or by role, job title, or the type of organization they represent. Key informant interview participants were compensated for their time with a $50 USD electronic gift card.

CHAPTER 4: Results and Analyses

Aim 1 Key Findings

Document Analysis/Review

Aim 1 was to identify health and social indicator outcome measures and assess for pattern(s) of racial disparities and inequities among Native Hawaiian and Pacific Islanders in the U.S. and Māori and Pacific Islanders in Aotearoa New Zealand. A document analysis or document review was conducted to achieve Aim 1. Documents were assessed for enumerated statistics of measured indicators and descriptive context. Publicly available data from the U.S. and Aotearoa New Zealand were substantial. They provided diverse contexts on Pacific Islander health disparities and inequities and enumerations of key indicators and measures of interest. A sample of 28 documents was systematically selected and reviewed (N=28, 100%); 14 documents were from the U.S. (N=14, 50%), and 14 documents were from Aotearoa New Zealand (N=14, 50%). Of the 28 documents, 17 were reports (N=17, 60.7 %), three were scholarly papers (N=3, 10.7%), three were strategic plans (N=3, 10.7%), three were policies or directives (N=3, 10.7%), and two were categorized as other or miscellaneous (N=2, 7.2%). Nine of 28 documents were government documents (N=9). Along with the document review, several data extractions were made from referred sources of evidence and data types mentioned in the documents through administrative Census registers and databases, health surveillance surveys, and cohort and research studies for reported statistics.

The selection of documents was assessed for content using an inductive approach to include the document and extracted information that aligned with the research questions and aims to investigate the extent of Pacific Islander health inequities associated with structural racism. A framework of seven questions was used to guide content extraction from the documents. Questions included whether the document: (a) identified Native Hawaiian, Māori, and/or Pacific Islander populations (N=25), (b) addressed health/public health issues, and provided any key factors, measures or indicators, and data used (N=27), (c) addressed historical context (N=20), (d) addressed political context (N=19), (e) addressed socio-cultural content (N=24), (f) explicitly addressed racism/structural racism (N=18), and (g) addressed health equity (N=13).

Populations of Interest. There were 24 documents that specifically identified or were focused on Native Hawaiians, Māori, and/or Pacific Islanders. Of the 14 documents from the United States, five documents specifically identified Native Hawaiians (N=5), three documents identified only Pacific Islanders (N=3), and three documents identified or focused on Native Hawaiians and Pacific Islanders or NHPIs (N=3). The documents that identified Pacific Islanders were specifically focused on the populations of the Compact of Free Association (COFA) communities from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Of the 14 documents from New Zealand, seven documents specifically identified Māori (N=7), two documents identified Pasifika or Pacific peoples (N=2), and four documents identified Māori and Pacific peoples (N=5). All documents reviewed from New Zealand identified Māori as of significant importance as the Indigenous peoples of New Zealand.

Health/Public health issues. The documents that discussed health/public health issues (N=27) mentioned health outcomes factors such as shorter life expectancy, disproportionate rates of mortality, morbidity, chronic and infectious diseases, physical and mental health status, disability, and wellbeing. For example, one report specifically focused on infectious diseases and the epidemiological profile of the Asian American, Native Hawaiian, and Pacific Islander populations in the U.S. Tuberculosis and hepatitis B were two diseases highlighted in the report. Asians, Native Hawaiians, and Pacific Islanders make up a disproportionate percentage of cases, in excess of the representation in the general U.S. population (Centers for Disease Control and Prevention, 2012). In another document reviewed from the U.S., Hawaiian Civic Clubs engaged in efforts to share information and health promotion initiatives to reduce the poor health outcomes among Native Hawaiians such as heart disease, cancer, diabetes, accidents, and problems with maternal, infant, and perinatal care. Engagement efforts included educational seminars and health screenings (Uchima, 2007). Other health issues related to the social determinants of health were described, particularly the lack of effective public policies to improve health and wellbeing, access to health and social care provisions, education, and housing. Two documents were mainly focused on the issues of housing. In one housing report from New Zealand, Pacific peoples and Māori were described as less likely to own their home or hold it in a family trust compared to other ethnic groups in New Zealand (Stats NZ, 2020a). Pacific peoples and Māori were also noted to rate their housing as unaffordable. Moreover, rates of severe housing deprivation were highest among young Pacific peoples and Māori. Māori and Pacific peoples also experienced higher rates of crowding and homelessness (Stats NZ, 2020a). Pacific peoples were disproportionately affected by intergenerational poverty and were more likely to reside in high deprivation areas, be unemployed, and have a lower median income than non-Māori or non-Pacific people (Health and Disability System Review, 2020). Other documents focused on employment and workforce factors, criminal justice, and cultural factors such as Indigenous rights, cultural safety, and self-determination. Health issues were also tied to historical factors and structural and societal issues such as discrimination and racism. Three reports were written and published during the height of the COVID-19 pandemic and briefly identified its implications for health to add to the context. One reported the challenges of COVID-19 in New Zealand during its second wave of the outbreak from August to September 2020, “Pacific peoples made up the vast majority (105 of a total 178 (59%)) of confirmed cases (Māori: 22%, European/other: 19%); with incidence rates of 48 per 100,000 for Pacific peoples, 21 per 100,000 for Māori and 3 per 100,000 for European and other New Zealanders” (Health Quality & Safety Commission New Zealand, 2021). Another document from the Department of Native Hawaiian Health, reported “high rates of pre-existing chronic diseases (e.g., cardiovascular disease, cancer, diabetes) make NHPIs especially vulnerable in public health emergencies like the current COVID-19 outbreak. Because of these existing health disparities, NHPIs are faced with a higher chance of severe symptoms and hospitalization due to COVID-19 than other racial and ethnic groups” (Look et al., 2020).

Historical Context. Several documents were comprehensive reports that provided extensive sections of historical background and context. The documents that identified the Indigenous people of the Hawaiian Islands and Aotearoa, the Native Hawaiians, and Māori respectfully, mentioned historical context that includes pre-Western contact and the colonization of their lands. For example, in the documents that reported Native Hawaiian health inequities, the historical context described a large Native Hawaiian population prior to the arrival of James Cook in 1778, ranging from 300,000 to 700,000. Native Hawaiians prior to western contact were also described to be “vibrant and robust people who were physically, emotionally, and spiritually healthy” (Look et al., 2020; Native Hawaiian Health Research Consortium, 1985).

The influx of foreigners such as explorers, missionaries, and laborers into Hawai’i also brought foreign diseases. Throughout the 1800s, infectious disease epidemics decimated the

Hawaiian population to about 30,000 in the late-1800s. Two documents mentioned The Great Māhele in 1848, which was a land distribution policy enacted by the Hawaiian Monarchy that was backed by the interests of foreign merchants, missionaries, and advisors and shifted land ownership to privately ownership (Look et al., 2020; Native Hawaiians Study Commission, 1983; United States Department of the Interior & Justice, 2000). This event was one of the many historical examples that left lasting repercussions for Native Hawaiians in losing land and severing their traditional and cultural relationship to the land. Another major historical event mentioned was the illegal overthrow of the Hawaiian Kingdom in 1893, during which a group of American businessmen and missionary descendants forcefully removed the reigning monarch, Queen Lili'uokalani. The U.S. had a strategic interest in establishing a military installation in the Kingdom, namely Pearl Harbor or, in earlier documents, Pearl River (Look et al., 2020; Native Hawaiians Study Commission, 1983; United States Department of the Interior & Justice, 2000).

The loss of power and sovereignty reinforced the effects of Western colonialism as Hawai'i was annexed and absorbed into the United States. The rights of the Native Hawaiian people were undermined, which was foundational to the traumatization, accumulating disadvantage, and cause of relentless inequities and disparities they experienced.

Most documents reviewed from New Zealand mentioned colonization and its negative effects on the health and wellbeing of the Māori population. One report stated that "because of colonization, and a system that has been designed to undermine Māori, Māori are overrepresented in negative statistics in all key socio-economic indicators which include unemployment, income, health, housing, education, and criminal justice" (Charters et al., 2020). Similar to the experiences of the Native Hawaiians, Māori were described in historical documents as "…Strong, rawboned, well made, Active people, rather above than under the common size, especially the Men; they are of a very dark brown color, with … very good features. … They seem to enjoy a good state of Health, and many of them live to a good old Age” (Moewaka Barnes & McCreanor, 2019).

The estimate of the Māori population pre-Western contact was over 100,000t. The Māori population declined due to the exposure to new diseases, guns, alcohol and tobacco, war, land alienation, malnutrition, and mass immigration from Europe. In the late 1800s, the Māori population fell to 42,000. Land confiscation and purchases continued with settler development, and laws enacted extended legislation over Māori assimilation under the British Crown government, including regulation of Māori rights and discrimination against the use of Māori language in schools, which culminated in loss, hardship, and trauma for Māori (Ellison-Loschmann & Pearce, 2006). In most documents reviewed from New Zealand, the importance of Te Tiriti o Waitangi (Treaty of Waitangi) was mentioned. Te Tiriti was the founding document of Aotearoa New Zealand and signed in 1840. It outlines the relationship between representatives of the British Crown and those of the Māori iwi and hapū (tribes and subtribes).

Another important historical event emerged in assessing documents that identified the COFA Pacific Islander populations. The origins of COFA began after the end of World War II when the United Nations assigned administering authority over the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau to the United States. The Trusteeship, called the Trust Territory of the Pacific Islands, designated the islands as “strategic in order to enable the United States to safeguard its own national security” (Hawaii Advisory Committee, 2019). The U.S. had exclusive authority over 3,000,000 square miles of the Pacific Ocean. Under the United Nations trusteeship system, the objectives for the U.S. were to (a) further international peace and security, (b) promote the political, economic, social, and educational advancement of the inhabitants of the trust territories, (c) to encourage respect for human rights, and (d) ensure equal treatment in social, economic, and commercial matters.

During the post-WWII Cold War period,, the U.S. conducted at least 67 nuclear tests in the Marshall Islands (Hawaii Advisory Committee, 2019). The tests sent irradiated coral dust throughout the atolls. These nuclear weapons tests had a particularly devastating effect on Micronesia and its people. Residents were forced to relocate, traditional agriculture became impossible on lands rendered unusable by fallout or military operations, and the economy became dependent on the U.S. (Hawaii Advisory Committee, 2019).

The U.S. failed to fulfill the objectives of the Trusteeship and it was terminated. Subsequently, the Compact of Free Agreement was developed and contained the provision that "The Government of the United States accepts the responsibility for compensation owing to citizens of the Marshall Islands, or the Federated States of Micronesia, (or Palau) for loss or damage to property and person of the citizens of the Marshall Islands, or the Federated States of Micronesia, resulting from the nuclear testing program which the Government of the United States conducted in the Northern Marshall Islands between June 30, 1946, and August 18, 1958" (United States Department of State, 2003). The next section will describe the COFA agreement in its political context.

Political Context. A total of 19 documents described the political context, specifically the governance structures and the political responsibilities pertaining to the relationships with the Native Hawaiians in the U.S. and Māori in Aotearoa New Zealand (N=19). For the documents reviewed from the U.S., a major theme that emerged was the political status of Native Hawaiians. Two reports paid particular attention to the challenges faced by Native Hawaiians due to their unique status as Indigenous people. In 1993, an Apology Resolution was issued by Congress and signed by President Clinton. The Resolution acknowledges the illegality of the overthrow of the Kingdom of Hawai’i in 1893. It recognizes that the U.S. acquired 1,800,000 acres of Hawaiian Monarchy Crown, government, and public lands without consent or compensation paid to the Native Hawaiian people. The Resolution contained legal recognition of Native Hawaiians as “descendent of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawai’i” (United States Department of the Interior & Justice, 2000). The Resolution was a commitment of the U.S. government to pursue “reconciliation” between the U.S. and the Native Hawaiian people. The State of Hawai’i also committed to similar efforts of reconciliation. Prior to the Apology Resolution, several legislations were enacted providing programs for Native Hawaiians or including them in laws and benefit programs that assist other native peoples. An example is the Hawaiian Homes Commission Act of 1920, which set aside a portion of public lands in Hawai’i to be administered by the Hawaiian Homes Commission (at the time, a component of the territorial government of Hawai’i), granted long term leases, and provided other types of assistance to Native Hawaiians. This legislation defined “Native Hawaiian” as “any descendant of not less than one-half part of the blood of the races inhabiting the Hawaiian Islands previous to 1778” (Native Hawaiians Study Commission, 1983). This definition using blood quantum created critical discussions around Native Hawaiian identity. Another example is the Native Hawaiian Health Care Improvement Act of 1988, which appropriated federal funding to support programs and services to improve the health status of Native Hawaiians and established the Native Hawaiian Health System and Scholarship Program (Look et al., 2020).

Although special legislation identified Native Hawaiians as an Indigenous people much like the Hawaiian Homes Commission Act of 1920 and the compact of the U.S. admitting

Hawai’i into the Union in 1959, it was not until 1974 that Native Hawaiians were included in legislation designed to benefit other Indigenous peoples like American Indians and Alaska Natives (United States Department of the Interior & Justice, 2000). The Native American Programs Act of 1974 was legislation to “promote the goal of economic and social self-sufficiency for American Indians, Native Hawaiians, other Native American Pacific Islanders (including American Samoan Natives), and Alaska Native” (Office of Intergovernmental and External Affairs (IEA), 2020). There are continued impediments and challenges faced by Native Hawaiians regarding political representation, parity with other Indigenous populations, autonomy, and self-governance (United States Department of the Interior & Justice, 2000).

The documents reviewed from New Zealand provided the political context of particular importance, the aforementioned te Tiriti o Waitangi or the Treaty of Waitangi. In one document, the te Tiriti is described as “a foundation document for public policy” (Ministry of Health NZ, 2020b). The significance of te Tiriti in Aotearoa established the contractual relationship between the British Crown and Māori peoples. There are two versions of the Treaty, one written in te Reo Māori known as Te Tiriti o Waitangi, and one in English, known as the Treaty of Waitangi. Both versions are accepted under law with implications on the nuances in language and interpretation. For example, te Tiriti states that the Māori chiefs can maintain tino rangatiratanga (sovereignty/authority) over taonga (all that they hold precious) and that the Crown (the British monarch) is to have kāwanatanga (governance) and delegated authority so that she can control her people. The Treaty in English was interpreted as the Māori chiefs ceding their sovereignty to the Crown (Morrison & Huygens, 2019).

Te Tiriti is broadly based on three principles: partnership, which addresses the sharing of power and decision making; the second is protection, which addresses the exercise of chieftainship and autonomy; the third is participation which addresses equity of access and outcome of participation. Te Tiriti recognizes Māori as tangata whenua or the Indigenous people, and the government is obligated to protect and adhere to its relationship with Māori (Durie, 1998).

The application and engagement of te Tiriti influence many of New Zealand's social policy and service provisions, in some cases included in social legislation (James, 1997). In several documents reviewed, the expressions of te Tiriti mentioned the breaches and violations of the Treaty that have particular implications for Māori health and wellbeing. One report primarily outlines the inquiries of health-related claims made to the Waitangi Tribunal, alleging "the primary health care framework [put forth under the New Zealand Health and Disability Act in 2000] has failed to achieve Māori health equity and is not sufficiently fit for that objective and current state" (Waitangi Tribunal, 2019). The Waitangi Tribunal is an independent commission of inquiry established in 1975 under the Ministry of Justice to investigate claims made by Māori against the Crown and make recommendations on claims relating to the practical applications and principles of te Tiriti (Stokes, 1992). Māori claims against the Crown are many and varied, and some claims include redress for the loss of language, culture, land, and resources (Waitangi Tribunal, 2019). Settlements of claims and reconciliation negotiations are made through the Office of Treaty Settlements, another office under the Ministry of Justice.

Another key political context described in the documents reviewed is the representations of Pacific Islanders in both the United States and in Aotearoa New Zealand. In the U.S., Native Hawaiians and Pacific Islanders are represented as one race group and as one of the minimum five race categories in the standards for the collection of race and ethnicity put forth by the Office of Management and Budget. In one surveillance report from the CDC, "most CDC disease-specific surveillance programs include categorization of the Asian population and the Native Hawaiian and Other Pacific Islander population as separate racial groups. However, some disease programs continue to report for a combined Asian/Native Hawaiian and Other Pacific Islander (Asian & Pacific Islander American Health Forum (APIAHF)) racial group. In some instances, case numbers are too small to allow meaningful statistical analysis, or data collection processes did not allow separation of Asians from Native Hawaiians and Other Pacific Islanders; in these instances, results are reported in the grouped category 'API' (Centers for Disease Control and Prevention, 2012)."

In another report, Executive Order 13125 – "Increasing Participation of Asian Americans and Pacific Islanders in Federal Programs" signed by President Clinton in 1999 categorized "Pacific Islander" as the aboriginal, Indigenous, native people of Hawai'i and other Pacific Islands within the jurisdiction of the United States" (Clinton, 1999). In Aotearoa New Zealand, Māori and Pacific peoples are represented as two separate race categories in the New Zealand data collection and analysis. One report stated a paucity of nationally reported data available for Pacific peoples and the individual Pacific Island ethnicities because the data collection and analysis systems are not designed to capture Pacific identities, outcomes, or experiences appropriately (Health Quality & Safety Commission New Zealand, 2021).

Lastly, in documents related to the Compact of Free Association (COFA) , Pacific Islanders who fall within COFA have unique political status and representation. Under the COFA, first approved in 1986, 1994, and later amended in 2003, citizens of the Freely Associated States of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau are legal nonimmigrants allowed, for indefinite periods, to live, work, and study in the United States without a visa. Because of their unique "nonimmigrant" status, many of these citizens are not eligible for many federal services like Medicaid/Medicare and other needs-based social services. COFA citizens are also not eligible to vote and are not eligible to apply for Federal Student Aid Loans for college (McElfish et al., 2019).

Socio-Cultural Context. The general consensus of the socio-cultural context mentioned in the reviewed documents offers insights into the population's perception within the societies that govern them and the cultural characteristics that make them unique. For example, in one report that assesses the New Zealand Health and Disability System, Māori and Pacific peoples were identified as priority-focused populations and are of the highest and most specific needs, including children and those with disabilities (Health and Disability System Review, 2020).

The report describes Māori, the Indigenous population, to be “highly connected through whakapapa (genealogy), and the wellbeing of individuals is strongly associated with the wellbeing of whānau (extended family). Their ability to access and participate in te Ao Māori (Māori worldview) and their familial and cultural connections provide a strong and enduring sense of identity and are prerequisites to good health” (Durie, 1999; Health and Disability System Review, 2020). In another report that focused on housing, those who have a connection to and engagement in Māori culture and proficiency in te Reo Māori, among others, are associated with lower rates of homeownership and higher rates of household crowding (Stats NZ, 2021a). Other cultural characteristics described the New Zealand Māori and Pacific populations as youthful, with median ages of 24.3 and 22.3, compared to 40.5 for European/White (Health and Disability System Review, 2020; Stats NZ, 2017). Mentions of Pacific cultural values included the importance of family, collectivism, communitarianism, spirituality, reciprocity, and respect which are values also found in Māori culture (Health and Disability System Review, 2020; Ministry of Health NZ, 2020a).

The connections between Māori and Pacific populations were apparent in a few of these documents. However, one document presented a tension of clear separation, “Aotearoa New Zealand is a nation that exists on Pacific islands but does not, and perhaps cannot, see itself as a Pacific Island nation or its people as Pacific Islanders. The mainstream health care system is designed neither for nor with Pacific peoples and fails to meet Pacific needs. It is an effect designed to get the failures in health care quality and health outcomes and thus the failures of human rights and rights of New Zealand citizenship for Pacific peoples …For most New Zealanders, Pacific Islanders are those who come from a few places to the north – mostly in Polynesia – to clean, to work in factories, to labor, and who had children here. The category that New Zealand has come to use, ‘Pacific Islander,’ has ensured that New Zealand ways of seeing are fundamentally disconnected from the Pacific” (Ministry of Health NZ, 2020a).

Few documents from New Zealand mentioned “monoculturalism” which was often used to describe the dominant, mainstream, Western or colonial models, particularly in the frameworks and institutions of health (Came, 2014; Ministry of Health NZ, 2020b; Morrison & Huygens, 2019). Colonialism was widely acknowledged in most documents reviewed from New Zealand. One document stated that a strength of studies from New Zealand that focus on inequity is the centering of Māori and conceptualizing racism as a determinant of health within a context of the enduring and harmful impacts of colonization (Talamaivao et al., 2020). While widely acknowledged, there are unique struggles to contend with the effects of colonialism that are both historical and ongoing.

In the documents reviewed from the United States, Native Hawaiian culture was mentioned as suppressed by religious and political beliefs and replaced by American-style Western values. In order to survive, many Native Hawaiians abandoned their culture in favor of the dominant one, while others simply gave up (Native Hawaiian Health Research Consortium, 1985). In the documents that mentioned the Hawaiian land tenure system changes, many Native Hawaiian commoners or makaʻāinana were alienated from the land, leading to the dispersal of the ʻohana (extended families) and communities.

The cultural values of Native Hawaiians were similar to those described by New Zealand Pacific Islanders, "cultural values such as collaborations, having direct face-to-face interaction, the importance of families, helping shape self-determination and decision making as a collective" (Look et al., 2020). One document mentioned that Native Hawaiians in Hawai'i live in large multi-generational households and densely populated neighborhoods. Another report described how COFA islander populations must reconcile their traditional family structure and cultural values when they emigrate to their new homes. Chuukese, for example, deeply value large families with the communal upbringing of children, which comes at odds with the push for family planning in the current health care system. They also come from a matriarchal society, where decision-making is often communal and led by the elder women (Hawaii Advisory Committee, 2019). For COFA Pacific Islanders, while they hold "nonimmigrant status," they are immigrants to the U.S. and face similar barriers with the unfamiliarity of the American systems.

Structural Racism. Of the 28 documents, 18 documents addressed racism/structural racism (N=18). The documents from New Zealand described the context of racism on multiple levels, such as individual or interpersonal racism and institutional and systemic racism. A New Zealand report described multiple claims of institutional racism in the New Zealand primary care framework and system. Examples given of institutional racism were "the failure to address negative social determinants." They were described as "an inaction in the face of need," the inaction can be conscious or unconscious. It can manifest through the deliberate actions or individuals or result simply from the routine administrations of public institutions that produce inequitable social outcomes (Waitangi Tribunal, 2019). One report described bias in the criminal justice system's processes and behaviors, although not necessarily racist in intent, nonetheless results in differential treatment of ethnic-minority groups (Morrison, 2009). Institutional racism was also mentioned as marginalization. One report described the structural biases that exist in the health care systems. "Māori providers are marginalized, and their input in policy decision is discounted and that a negative differential compensation for Māori providers is maintained" (UN Committee on the Elimination of Racial Discrimination (CERD), 2017).

Explicit descriptions of racism from documents reviewed from the U.S. were limited. One report described how many Indigenous populations endure structural and interpersonal racism regularly. Examples included the forced removal from their ancestral lands and the enactment of compulsory and discriminatory assimilation policies and strategies into mainstream society (Look et al., 2020). In one historical example from the Native Hawaiian Study Commission, "during the Republic of Hawai'i (1894-1900) [post-overthrow], property qualification and other restrictions for voters would openly discriminate against poor native Hawaiians and all Asiatics in Hawai'i" (Native Hawaiians Study Commission, 1983).

Lastly, in a report on the COFA populations, many testimonies included outlined multiple incidences of anecdotal experiences of racism and discrimination. For example, one testimony describes the lack of language access, "denial of language access has been and continues to be a major civil rights issue for Micronesians in Hawai'i." There has been a challenge to get qualified interpreters for COFA nation languages. The inability to receive and share information and communicate affects their ability to acquire housing, obtain employment and receive government services that they are legally entitled to (Hawaii Advisory Committee, 2019).

Health Equity. Half of the sampled documents mentioned or identified health equity (N=13). One document describes health equity as defined by the New Zealand Ministry of Health as "the differences in health that are not only avoidable but unfair and unjust. Equity recognizes different people with various levels of advantage require different approaches and resources to get equitable health outcomes. Health equity is an enabler of wellbeing and is a critical component in rebalancing approaches and resources to meet different needs." (Ministry of Health NZ, 2020a). Another report states that health equity is the commitment to and fulfilling the obligations of te Tiriti o Waitangi (Ministry of Health NZ, 2020b). Another document described that the dominant language in the [New Zealand] legislation and policy framework is "reducing disparities" or "reducing inequity," rather than a commitment to achieving equity of health outcomes for Māori. The report reiterated that "including an expressly stated, stand-alone commitment to achieving health equity should not be controversial and that achieving health equity should be among the ultimate purposes of any just health system" (Waitangi Tribunal, 2019). The Health and Disability System Review reported that "health equity for Māori is substantially influenced by the unequal distribution of socioeconomic determinants of health" (Health and Disability System Review, 2020)

In the documents from the U.S., one definition of equity as "the consistent and systematic fair, just, and impartial treatment of individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. The term "underserved communities" refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of "equity" (U.S. Department Health and Human Services, 2021). One report describes health equity from a "Western lens" and is often understood as simply the absence of systematic disparities in health between racial and ethnic groups. Achieving health equity for Native Hawaiians means that the Hawaiian community's language and cultural and ancestral knowledge are central to their identity and social relations and are intimately tied to their physical and emotional wellbeing (Look et al., 2020).

An inventory of indicators and data points was created to assess for patterns in disparities and inequities. Trends in health indicators were described from multiple-year reference points ranging from five to ten years among adults if the data was available using a series of national-level and state-level data sets. Most statistics were self-reported, age-adjusted, and stratified by race/ethnicity and sex/gender, where population subgroup information is available. Indicators that reported statistics for Native Hawaiian and other Pacific Islanders (and subgroup), Māori, Non-Māori, and Pacific were extracted, along with statistics for Non-Hispanic Whites (U.S.) or European White (Aotearoa New Zealand) as a population reference. Race/ethnicity data are presented to the extent that the data collected with large enough samples for analysis. Many quantifiable statistics were integrated into the literature review in Chapter 2.

Due to the exploratory nature and design of the study, the selection of measures presented in this study and criteria may be generalized and may not be mutually exclusive to the context of racism/structural racism and the targeted population of the study. However, measures were considered within the particular context based on supporting evidence and relevance to Pacific

Islanders. Key proxy measures were examined to consider historical evidence of discrimination and disadvantage oriented towards the specific populations. For brevity and justification, the measures that are presented below are not meant to be exhaustive and are categorized in conceptualized domains.

General Sociodemographic Measures

Race and Ethnicity. In the context of the U.S., the Office of Management and Budget (OMB), under the revised Directive 15, advised a standard for race and ethnicity reporting of federal data. The OMB minimum categories for race are American Indian or Alaska Native, Asian, Black, or African American, Native Hawaiian or other Pacific Islander (NHPIs), and White. The minimum categories for ethnicity are: Hispanic or Latino and Not Hispanic or Latino. Data specifically reported for NHPIs, and the granular subgroups were not consistently available. Several documents reported aggregated data with other racial categories. (e.g., Asian).

In New Zealand, similar to the U.S. OMB standards, in terms of a broader legislative context, the Statistics Act 1975 made it a statutory requirement for ethnicity data to be collected in population consensus by Statistics New Zealand (Cormack, 2010). Under the Treaty of Waitangi, the founding document that recognized the contractual relationship between two sovereign nations, the Māori as tāgata whenua (people of the land) and the British Crown (colonizer), there have been numerous policies and practices that classifies the Māori as a discrete ethnic or racial category and the collection of specific Māori data is imperative to the Treaty obligations (Chin et al., 2018; McCreanor & Nairn, 2002; Rata & Zubaran, 2016). There are multiple methods of categorizing ethnicity information in New Zealand, such as prioritized, total response, and single/combination. The most common method is the prioritized method used by the Ministry of Health and in health research. Prioritized methods are where individuals are classified in prioritized order: Māori, Pacific Peoples, Asian, Middle Eastern/Latin America/African (MELAA), Other, and European (Boven et al., 2020).

Socioeconomic Status. Another robust measure that was considered with relevance to structural racism health outcomes is socioeconomic status (SES). In the U.S., multiple indicators were used, such as poverty level in percentage, education attainment (in percentage), median household income in USD, and occupational status, e.g., in percent employed or unemployment rates. Indicators were reported estimates from the U.S. Census Bureau, American Community Survey. Homeownership and homelessness were other indicators used for socioeconomic status. Homeownership was reported by the U.S. Census Bureau, American Community Survey. Data reporting homelessness were reported from point-in-time estimates of sheltered homelessness from the Annual Homeless Assessment Report to Congress by the U.S. Department of Housing and Urban Development. U.S. poverty, educational attainment, median household income, employment status, and homeownership 2018 data reported from U.S. Census Bureau, American Community Survey, 1-year estimates, 2018 and 3-year estimates, 2017-2019. Select general sociodemographic measures for NHPIs are presented in Table 3 below.

In New Zealand, select indicators were stratified from the NZDep indicators to compare with U.S. indicators. New Zealand does not have an official national poverty line but uses Economic Living Standard Index (Braveman et al.) scores, which range from zero (low living standard) to 60 (high living standard) and are grouped into seven levels and reported in percentage proportion of the population. Low-income thresholds or poverty lines can be used, such as a “fixed line measure” that anchors the poverty line and 60 percent of the median household income in NZD. Educational attainment was measured using Education qualification indicators, such as a bachelor’s degree or Level 7 qualification, in percentage proportion.

Occupational status was reported in percentage employed or unemployed. Indicators were reported from Statistics New Zealand, collected from the 2018 New Zealand Census. Homeownership in New Zealand is measured in tenure, and tenure security (those that owned home) was reported by Statistics New Zealand. Homelessness measures were limited. Homelessness indicators were measured using severe housing deprivation estimates reported from the Ministry of Housing and Urban Development, Statistics New Zealand. Select general sociodemographic measures for Māori and Pacific people are presented in Table 3 below. The concept of SES illustrated a range of factors encompassing economic resources, power, and/or prestige that can influence health at various times in the life course and at various levels (e.g., individual, household, neighborhood/community) and through different pathways (Braveman et al., 2010). In a paper by Link and Phelan, the authors built on and developed the theory of fundamental causes to explain the associations between SES and mortality that have persisted over centuries despite changes in disease and risk factors (Link & Phelan, 1995). Social and economic resources are important determinants and can be used in diverse ways and in different situations.

Health Status Indicators and Outcome Measures

Life Expectancy. Although it is a general health measure, life expectancy is an important health status indicator that provides substantial information and assessment of the current population's health. According to the OECD, gains in life expectancy can be attributed to several factors, including rising living standards, improved lifestyle and better education, and greater access to quality health services (OECD, 2020). The losses and differences in life expectancy between racial and ethnic groups may elucidate how structural racism is manifested. In an article by Gee et al., a framework was conceptualized which utilizes the function of age and time, a life course perspective in which racism can structure one's time in asset-building contexts (e.g., education) or disadvantaged contexts (e.g., incarceration). This variation in time and exposure can contribute to racial inequities in life expectancy and other health outcomes in the life course and over generations (Gee et al., 2012).

Life expectancy measures were reported from the U.S. Census Bureau 2014 projections of life expectancies for 2015 to 2060. Life expectancy at birth measured in the U.S. is based on mortality for the year ending June 30 of the indicated year. Data for subgroups was limited at the national level; state-level surveys such as the 2018 Hawai'i Health Survey provided statistics for various specific Pacific Islanders populations and Native Hawaiians. In New Zealand, life expectancy was reported as projected estimates for 2017-2019 from the New Zealand Census and Mortality Collection by the Ministry of Health, Statistics New Zealand. Life expectancy statistics of are presented in Table 4a below.

Disease Prevalence. Disease prevalence for diabetes, heart disease, and obesity were reported from Hawai'i Health Matters Dashboard, Hawai'i BRFSS, 2018. Cancer mortality rates for all cancers, per 100,000 were reported from National Vital Statistic report, 2018. Disease prevalence for diabetes, heart disease, and obesity were reported from the New Zealand Health Survey 2018/19. New Zealand cancer mortality rates for all cancers were reported per 100,000 from 2010-2012 New Zealand Health Survey. Disease prevalence and cancer mortality rates are presented in Table 4a below.

Mental Health. Another construct or domain of measures to consider in measuring structural racism is the indicators that measure mental and behavioral health status. An extensive body of literature connects racism with poor mental and behavioral health outcomes. The legacies of slavery and colonization and other contextual factors can be linked to the poor mental health statuses of many Blacks, Indigenous, and People of Color.

In the U.S., several indicators were available to measure mental health status, including prevalence in proportion percentage of frequent psychological distress, tobacco and alcohol use, and access to and use of mental health services. Data was reported from SAMSHA, National Vital Statistics Reports, National Survey on Drug Use and Health, CDC, and Hawai’i Health Matters for 2018.

In New Zealand, indicators for mental health included prevalence in proportion percentage of psychological distress or mental distress, percentage of tobacco and alcohol use, rates of depression, suicide, and mental health and addiction service used. Data was reported from the 2018 New Zealand Health Survey, Statistics New Zealand, Ministry of Health, and Mental Health Information National Collection (MHINC). Mental health status statistics are presented in Table 4b. Health Status and Outcome measures below.

Maternal and Infant Mortality. The death of an infant or a mother is an event that serves as a measure of how well a society ensures the health of its people, particularly its women and children. Therefore, disparities in infant and maternal mortality are indicators of inequities that go much deeper than health status, pointing to social, institutional, and structural inequities (Torres et al., 2020). The research and literature on adverse birth outcomes and their association with racism are broadly documented among Black women. For example, Black women continue to be at increased risk of preterm birth and infant mortality compared to White women in the United States and in California (Chambers et al., 2019). Maternal and infant mortality rates for NHPIs in the U.S. were reported from the National Vital Statistics System. Maternal mortality rates are per 100,000 live births, and infant mortality rates are per 1,000 live births, based on data from the National Vital Statistics. In Aotearoa New Zealand, maternal mortality rates are also per 100,000 live births. Infant mortality rates are per 1,000 live births. Infant outcomes were more commonly reported than maternal outcomes. Maternal and infant mortality rates for New Zealand were extracted from the 2018 New Zealand National Perinatal and Maternal Mortality Review Committee (PMMRC) report and Statistics New Zealand. U.S. and Aotearoa New Zealand maternal and infant mortality statistics are presented in Table 4c. below.

Health Care System Access and Utilization

Health care system access and utilization are key drivers that affect health status and outcomes. Literature has shown a disproportionate impact on different population groups with gaps in health insurance coverage, uneven access to services, and quality and service utilization challenges. Insurance coverage was the indicator used for this measure.

Insurance Coverage. For the U.S., insurance coverage data was collected using the percentage proportion of those who had private insurance, public insurance (e.g., Medicaid, Medicare, or CHAMPVA), and were uninsured. Data was reported from the Current Population Annual Social and Economic Supplement (CPS ASEC) and 1-year estimates from the American Community Survey reported for 2019. Use of mental health services data reported from National Survey on Drug Use and Health, 2018-19. For New Zealand, private health insurance coverage (PHI) was the indicator used for this measure as New Zealand provides health care for all by the government. PHI and use of mental health services were reported from the 2018 New Zealand Health Survey, Statistics New Zealand. Health care system access and utilization statistics are presented in Table 5 below.

Representation in the Criminal Justice System

Representation in the criminal justice system was the last measure of interest. Incarceration is an important driver of social and health inequities, which has been defined by the extreme overrepresentation of the poor and people of color in criminal justice institutions (Washington & Fullilove). There are historical origins of the institutions of policing and incarceration that are integrally tied with the socioeconomic and racialized structures. The disproportionate rates of minorities in the criminal justice system in comparison with whites suggest the logic of structural racism. Incarceration rates reported for Native Hawaiians and Pacific Islanders were limited at the national level after assessing data from the Department of Justice. Hawaiʻi state data reported in *A Community of Contrasts: Native Hawaiians and Pacific Islanders in the United States, 2014* (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014). Incarceration rates in New Zealand were reported as prison population rates in 2019 by percentage proportion reported by the New Zealand Department of Corrections. Representation in the criminal justice system statistics is presented in Table 6 below.

The following are table summaries of selected indicators. Data and statistics are presented as available from reports and repositories at the time of the analysis and will be presented by country profiles, the U.S. and Aotearoa New Zealand. Table 3 describes the general social demographic measures of the U.S. and Aotearoa New Zealand, such as race and ethnicity, and socioeconomic status (poverty status, educational attainment, median household income, employment status, and housing status). Table 4 describes Health Status Indicators and Outcome Measures such as life expectancy, disease prevalence, mental and behavioral health, and maternal and infant mortality. Table 5 describes health coverage, and Table 6 describes incarceration rates. It was not possible to include all available indicators reported in the documents assessed in this study. However, it was important to illustrate patterns and trends to further the investigation of this study. The following section will present the results and findings of Aim 2, the key informant interviews.

Table 3.

General Sociodemographic Measures of U.S. NHPIs and Non-Hispanic White and New Zealand Māori, Pacific and European, 2018

	Living at or below poverty (%)	**Educational attainment (%)**	**Median household income (USD or NZD)**	**Employment rate (%)**	**Unemployment rate (%)**	**Homeownership (%)**	**Homelessness (%)**
United States							
NHPI	14.8	23.8	60,734	64.9	5.3	57.7*	--
Non-Hispanic White	9.0	36.9	65,845	55.8	3.5	73.3	--
U.S. Subgroup							
Native Hawaiians	11.4	11.1	65,398	60.3	8.3	55.7	--
Samoan	20.4	11.9	62,913	56.5	6.7	27.5	--
Tongan	16.2	115	51,932	61.9	5.5	36.7	--
Guamanian/Chamorro	9.0	11.7	80,996	57.6	7.0	30.1	--
Marshallese	51.1	2.3	32,650	46.4	9.4	7.7	--
White	11.4	22.0	68,173	56.3	8.3	51.2	--
Aotearoa New Zealand							
Māori	23.0[a]	8.4	24,300	47.7	8.1	31.0	32.3
Pacific	22.0[a]	7.7	24,300	49.7	7.1	21.0	24.4
European	11.0[a]	13.3	34,600	50.2	3.2	58.0	34.3

Note: U.S. poverty, educational attainment, median household income, employment status, and homeownership data reported from U.S. Census Bureau, American Community Survey, 3-year estimates, 2017-2019, reported: 2018. New Zealand poverty, educational attainment, median household income, employment status, homeownership and homelessness data were reported from Statistics New Zealand, 2018.

*Rate reported for Asian or Native Hawaiian and Pacific Islander combined

[a] Rate reported using the fixed line measure, rates reported using ELSI scores in the New Zealand Health Survey were 16 percent of Māori and 24 percent of Pacific were reported any degree of hardship

Table 4a.

Health Status Indicators and Outcome Measures – Life Expectancy 2019-2020 projections for U.S. NHPIs and Non-Hispanic Whites and 2017-2019 projections for Māori, Pacific and Europeans in New Zealand; Diabetes, Heart Disease and Obesity prevalence rates of U.S. NHPIs and Non-Hispanic White adults age 18 and over, and New Zealand Māori, Pacific and European adults age 25 and older, 2018; and Cancer Mortality rates of U.S. NHPI and Non-Hispanic adults age 18 and over, 2018 and New Zealand Māori and non-Māori adults 25 and older, 2010-2012

	Life Expectancy (in years)	**Diabetes prevalence (%)**	**Heart disease prevalence (%)**	**Obesity prevalence (%)**	**All Cancer Mortality (per 100,000)**
United States					
NHPI	80.8	19.8	6.0	--	389.1
Male	83.2	--	--	--	--
Female	78.5	--	--	--	--
Non-Hispanic White	80.6	8.0	5.7	--	135.2
Male	78.4	--	--	--	--
Female	82.7	--	--	--	--
U.S. Subgroup					
Native Hawaiians	--	31.1*	3.1*	19.8*	--
Pacific Islanders		11.6*	3.4*	41.6*	--
White	--	5.9*	3.1*	18.9*	--
Aotearoa New Zealand					
Māori	--	6.7	3.6	48.1	215.6
Male	73.4	--	--	--	--
Female	77.1	--	--	--	--
Pacific	--	10.7	2.7	63.5	120.3[a]
Male	75.4	--	--	--	--
Female	79.0	--	--	--	--
European	--	4.7	4.7	29.5	120.3[a]
Male	81.0	--	--	--	--
Female	84.5	--	--	--	--

Notes: U.S. life expectancy data is reported from U.S. Census Bureau 2014 estimated projections for 2019-2020,
New Zealand life expectancy data is reported from the 2018 New Zealand Health Survey estimated projections for 2019-2020 U.S.
U.S. statistics for diabetes, health disease, obesity prevalence and cancer mortality rates are reported from reported from 2018 National Vital Statistics Reports, CDC and New Zealand statistics are reported from 2010-2012 and 2018-2019 New Zealand Health Survey, Statistics New Zealand, Ministry of Health
*State-level data reported from 2018 Hawai‘i Health Survey, Hawai‘i State BRFSS.
[a] Data reported for non-Māori

Table 5b.

Health Status Indicators and Outcome Measures – Psychological Distress, Tobacco and Alcohol Use and Suicide rates, for U.S. NHPIs and Non-Hispanic White adults age 18 and over and New Zealand Māori, Pacific, and European adults age 25 and older, 2018

	Frequent psychological distress (%)	Tobacco Use (%)	Alcohol use (%)	Suicide rate (per 100,000)
United States				
NHPI	6.9	33.9	56.1	11.9
Male	--	--	--	--
Female	--	--	--	--
Non-Hispanic White	7.8	22.1	74.0	18.1
Male	--	--	--	--
Female	--	--	--	--
U.S. Subgroup				
Native Hawaiians	13.8	22.8*	51.2*	--
Pacific Islanders	10.3	19.8*	51.0*	--
White	9.1	11.8*	64.1*	--
Aotearoa New Zealand				
Māori	13.4	33.4	83.1	18.2
Male	--	--	--	--
Female	--	--	--	--
Pacific	12.5	24.7	62.0	7.8
Male	--	--	--	--
Female	--	--	--	--
European	8.1	12.7	85.8	12.8[b]
Male	--	--	--	--
Female	--	--	--	--

Notes: Psychological distress, tobacco use, alcohol use and suicide mortality were reported by SAMSHA, National Vital Statistics Reports, CDC; and 2018 Hawai‘i Health Survey, Hawai‘i State BRFSS; 2018 New Zealand Health Survey, Statistics New Zealand, Ministry of Health, and Mental Health Information National Collection (MHINC)

*State-level data reported from Hawai‘i BRFSS
[b] Data reported for Other (non-Māori and non-Pacific)

Table 6c.

Health Status Indicators and Outcome Measures – Maternal and infant mortality rates of U.S. NHPIs and Non-Hispanic Whites, and New Zealand Māori, Pacific and European, 2018

	Maternal Mortality (per 100,000)	Infant mortality (per 1000 live births)
United States		
NHPI	13.8*	9.4
Non-Hispanic White	13.4	4.6
Aotearoa New Zealand		
Māori	23.38	5.9
Pacific	23.88	6.2
European	10.72	2.8

Notes: Maternal and infant mortality data reported from 2018 U.S. National Vital Statistics Reports and 2018 Reports of New Zealand National Perinatal and Maternal Mortality Review Committee (PMMRC), Statistics New Zealand.
*Rate reported for Asian or Native Hawaiian and Pacific Islander combined

Table 7.

Health Care Access and Utilization for U.S. NHPIs and Non-Hispanic White adults age 18 and older, and New Zealand Māori, Pacific, and European adults age 25 and older, 2018

	Insurance coverage – public (%)	**Insurance coverage – private (%)**	**Uninsured (%)**	**Use of Mental Health Services (%)**
United States				
NHPI	34.0	65.8	9.1	6.1
Non-Hispanic White	34.3	74.7	6.3	--
U.S. Subgroup				
Native Hawaiians	--	--	10.2*	--
Pacific Islanders	--	--	18.0*	--
White	--	--	7.9*	--
Aotearoa New Zealand				
Māori	--	22.6	--	28.0
Pacific	--	18.9	--	6.0
European	--	36.9	--	3.8**

Notes: Insurance coverage data reported from U.S. Census Bureau American Community Survey 1-year estimates, 2017-2018 and 2018 Hawai‘i Health Survey, Hawai‘i State BRFSS.
Use of mental health services data reported from National Survey on Drug Use and Health, 2018-19.
New Zealand private insurance coverage data and use of mental health services reported from 2018 New Zealand Health Survey, Statistics New Zealand
*State-level data reported from Hawai‘i Health Survey
**Data reported for Other (non-Māori and non-Pacific)

Table 8.

Representation in the Criminal Justice System, Hawai‘i (U.S.) growth in number of incarcerated, 2002-2010 and New Zealand prison population, 2019

	Incarceration rates or prison population (%)
Hawai‘i state (U.S.)	
NHPI	8.0*
Other	-10.0*
Aotearoa New Zealand	
Māori	52.7
Pacific	11.5
European	30.5

Notes: Hawai‘i state data reported in A Community of Contrasts: Native Hawaiians and Pacific Islanders in the United States, 2014 Statistics from U.S. Department of Justice, office of Justice Programs, Bureau of Justice Statistics, National Prisoner Statistics 2002–2010. New Zealand population rates reported from New Zealand Department of Corrections, 2019.

*Hawai‘i state-level incarceration rates are presented as growth in number of incarcerated by NHPI and total state population, 2002-2010, while the number of prisoners overall decreased in Hawai‘i (-10%), there was an 8% increase in the number of NHPI incarcerated in the state (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014)

Aim 2 Key Findings

Key Informant Interviews

Aim 2 had two parts, (2a) was to describe the cause of racial disparities and inequities among Native Hawaiian and Pacific Islanders in the U.S. and Māori and Pacific Islanders in Aotearoa New Zealand, and (2b) was to explore the way forward with lessons learned and recommendations to improving Indigenous Pacific Islander health and social outcomes and health equity. To achieve Aim 2, key informant interviews were conducted. Twenty-seven semi-structured key informant interviews were conducted between September 2021 and February 2022, (N=27). Over 90 connections were made from both the U.S. and Aotearoa New Zealand during the recruitment process through cold and introductory referral emails. Participating key informants were community experts who have experience working with Indigenous and Pacific Islander populations within the scope of public health in the U.S. or Aotearoa New Zealand. The final sample included 15 participants from the U.S. (N=15, 56%) and 12 participants from Aotearoa New Zealand (N=12, 44%). Before participating in the key informant interview, participants were asked to provide informed consent and complete a short online demographic questionnaire. Table 7 summarizes the demographic characteristics of key informants who participated in the interview.

Table 9.

Demographic Characteristics of Key Informant Interview Participants Frequencies

	Frequency (N)	Percent
Age (in years)		
18-25	1	3.7
36-45	9	33.3
46-55	10	37.0
56-70	6	22.2
>70	1	3.7
Gender		
Male	11	40.7
Female	16	59.3
Non-Binary/Third Gender	0	0
Education Level*		
Received a Bachelor’s Degree/Level 7-8 qualification	5	18.5
Received a Graduate Degree/Level 9-10 qualification	21	77.8
Decline to answer	1	3.7
Race/Ethnicity**		
American Indian/Alaska Native	0	--
Asian/Asian American	2	7.4
Hispanic/Latino	0	--
White/European	1	3.7
Native Hawaiian	3	11.1
Māori	7	25.9
Pacific Islander	(3)	11.1
Samoan	2	--
Tongan	1	--
Other	0	--
Middle Eastern/Latin American/African NZ	0	--
Other	0	--
Multi-racial***	11	40.7

Notes: Data were assessed as a combined sample

*Education levels qualifications are estimated equivalents of the U.S. Census and New Zealand Qualifications Framework

**Race/Ethnicity categories were according to the U.S. OMB Standards and New Zealand Review of Measurement of Ethnicity.

***Participants had the option to select all that apply and, of interest if the participant identified “Pacific Islander” or “Other” to specify. Several participants selected more than one race

In the demographic questionnaire, participants were asked a few questions to describe their role and work experience and additional questions about health and health disparities among Pacific Islanders, structural racism, and health equity. Several responses to the questions will be integrated into the interview theme findings below. Table 8 summarizes the work experience characteristics of the key informants who participated in the interview. Participants were also asked if they collaborated with other organizations/entities (N=26), if they worked directly with community groups (N=23), and/or supervised staff members that work directly with community groups (N=26). The leadership or position titles of the participants were diverse. Examples that participants identified included: Academic professor, Chair, Director or Executive Director, General Manager, Head of Department of Public Health, Consultant, Community Elder, Cultural practitioner, Medical Doctor/Primary Care or Specialist Physician, Policy Analyst, City Councilperson, State Representative, and Leader or Team/Project Lead. During each interview session, participants were given the opportunity to describe their work and community experiences within the capacities of their positions more in-depth and related to Pacific Islander health.

Table 10.

Work Experience Characteristics of Key Informant Interview Participants Frequencies

	Frequency (N)	Percent
Years of public health/community health experience (in years)		
5-10	3	11.1
11-20	10	37.0
21-30	9	33.3
31-40	4	14.8
41+	1	3.7
Type of Organization*		
Government	6	--
Non-Government	11	--
Community-based	5	--
Academic	11	--
Other	2	--
Primary Area of Work		
Health advocacy/policy	9	33.3
Other advocacy/policy	1	3.7
Urban Planning	1	3.7
Research	2	7.4
Public sector business	1	3.7
Direct health/social care services	4	14.8
Other direct services	1	3.7
Other	8	29.6
Issue Focus*		
Quality/affordable housing	10	--
Community safety and violence prevention	3	--
Recreation opportunities, parks, and open spaces	4	--

Quality public education	9	--
Community economic development	11	--
Racial justice	15	--
Employment/workforce/community development	12	--
Transportation planning	2	--
Environmental justice	10	--
Food security/access to healthy food	9	--
Early childhood development	5	--
Other	12	--
Pacific Islander populations served*		
Micronesian		
Carolinian	7	--
Chamoru/Chamorro	10	--
Chuukeese	11	--
Marshallese	9	--
Palauan	11	--
Pohnpeian	10	--
Yapese	9	--
Melanesian		
Fijian	8	--
Papua New Guinean	7	--
Polynesian		
Hawaiian/Native Hawaiian	19	--
Tongan	20	--
Samoan	21	--
Tokelauan	13	--
Māori	15	--
Other	1	--
Don’t know/declined/not sure	2	--

Note: *Participants were given the option to select all that applied and if “Other” to specify

Aim 2a Findings from Key Informant Interviews

Aim 2 used the results of the interviews to describe the perceived causes of racial disparities and inequities among Pacific Islanders. These findings were used to answer research question two, “How does the community perceive the cause of disparities and inequities?” Two primary themes emerged from the analysis of the key informant interviews that shed light on how the community perceives the cause of Pacific Islander health disparities and inequities. For theme 1, Participants described how structural racism is operationalized as a major cause of inequities. In theme 2, participants described how differing worldviews and perspectives of health underscore the importance of culture and how this can create barriers and give rise to the experience of structural racism. Several sub-themes have emerged throughout the analysis and will be integrated into the summaries below. Quotes are used to enrich the results and are presented verbatim. The use of terms in-language is an attempt to preserve the nuances of the discourse of the Pacific Island communities.

Participants were asked in the demographic questionnaire to rate their level of agreement with the following statements on structural racism. Most participants “strongly agreed” or “agreed” on the four statements.

Table 11.

Level of Agreement to Structural Racism Statements, frequency in percentage (N)

	Agree	**Strongly Agree**	**Don't know/ Declined**	**Total**
Statements				
Racism is a public health issue that impacts Native Hawaiian, Māori, Pacific Islander health and wellbeing.	14.8 (4)	81.5 (22)	3.7 (1)	100 (27)
Racism is a determinant that impacts Native Hawaiian, Māori, Pacific Islander health and wellbeing.	11.1 (3)	85.2 (23)	3.7 (1)	100 (27)
Differential access to the goods, services, and opportunities of society by race affects the health of Native Hawaiian, Māori, and Pacific Islanders.	7.4 (2)	88.9 (24)	3.7 (1)	100 (27)
Structural racism exists among Native Hawaiian, Māori, Pacific Islander communities.	14.8 (4)	85.2 (23)	0 (0)	100 (27)

The following section addresses the two major themes that emerged to address research question 2.

Theme 1: How structural racism is operationalized

A major theme that emerged to describe the cause of racial disparities and inequities among Pacific Islanders is structural racism. Participants shared the multiple areas in which structural racism is operationalized. Several sub-themes have emerged to describe several mutually reinforcing domains that shaped the way disparities and inequities are perpetuated. The perceived aspects of structural racism have created unique historical, political, and sociocultural experiences for Indigenous and Pacific Islanders in the U.S. and Aotearoa New Zealand.

Colonialism. The colonization experience was mentioned in multiple interviews. Colonization or colonialism was often referenced in many ways. For example, a few participants described colonialism as a historical event from the arrival of foreigners, as a system that redistributed power and eliminated Native systems and people. Others have described colonialism as an ongoing process that continues to oppress and disenfranchise Pacific Islanders throughout their life course. Participants provided examples of how colonialism impacts their day-to-day life, including the systems and institutions they interact with. A few participants explained that even some community members feel they have become "colonized" by conforming to and operating within mainstream systems and institutions.

> "Colonialism and colonization all is determinants of health for people right good or bad. Unfortunately, mainly a lot of it has been bad and that it continues, although historical factors or events cannot be altered. They [colonialism and colonization] in theory happened. It has created a situation, politically, socially, structurally that has led to disadvantage for people. Which puts them at a disadvantage, starting from birth and even prior to birth" (Professor & Chair, U.S.)

> "Part of some of the structural racism is also what contributed to the colonization of many of our Islands and that colonization isn't like a monolith. It didn't look the same for all of us and it didn't impact us all the same way, right? Like what happened in Hawaii is different from what happened to Guam, is different from what happened to American Samoa, is different to what happened to our COFA communities." (Project Director, U.S.)

> "Like a major way that colonialism has operated in Hawaii and the US is to turn collective peoples into individuals who are members of particular races so, but you know, I think Indigenous study scholars have really pointed out how these two categories aren't

> different, and they are distinct. Indigeneity and race are not the same thing, even though over and over the US, has tried to assert that they are like in the Rice vs. Cayetano decision that you know, saying that "ancestry is a proxy for race." (Community Leader and Professor, U.S.)

> "And I think there is a general understanding that it continues to impact us, but it is still felt as though it's an event that happened long time ago. My opinion I think, and I'm not a scholar of this, but I think that colonization was, I agree that it was something that happened at one point of time, but I also think that it evolved, it has evolved and continues to exist within the current constructs of our communities, and so there was a beginning point of it but it's like a…I don't know I keep thinking of like an evil spirit that just like passes through the host in different forms. In the next century it looks different, but it's still there and it continued. I think it continues to be perpetuated in different ways that allows for it to evolve and continue to exist within our own psyche as Pacific Islanders who have been colonized" (Project Director, U.S.)

Historical and Intergenerational Trauma. Participants shared that colonialism continues to impact the health and wellbeing of Pacific Islanders beyond the original historical events. One participant described that trauma could accumulate over time and across the lifespan and generations. Another participant draws from the experience of colonialism and how it has affected their family's economic opportunities. The exposure and lack of healing from trauma can precipitate the development of the negative physical, psychological, and social conditions as one participant connect trauma to the social conditions that impact mental health and overall health.

"… I think it really stems from historical trauma, the trauma from colonization you know. It builds up over each generation, I look at, if you look from the generation of when colonization happened, it just each generation seems to get a little bit unhealthier … And its historical trauma. It's not only that historical trauma, but also the day-to-day trauma building up on top of it." (Policy Analyst and Assistant Professor, U.S.)

"Yeah, I guess from like the Native Hawaiian perspective, when you take our culture, that was robbed –the land, the Kingdom, our way of governance. [It was] supplanted with a white power structure or dominating society that basically told you, 'you're now our subjects.' When you don't need to be subjugated, right? Then you're perfectly fine on your own. I think there's some lingering damage to that, even though, like I wasn't there, what did it mean for my family, like my family who worked on Moloka'i on the plantations you know. Left Moloka'i, to go to O'ahu for opportunities. And eventually, left for California for opportunities, right?" (Executive Director, U.S.)

"The sense of hopelessness and despair, that historical trauma related issues and I strongly believe that psychological, that these emotional issues really precede the physical health outcomes and put people at risk and there's been a lot of studies, looking at the reports of depression, for example." (Professor and Chair, U.S.)

"And the intergenerational trauma that it's created because of this connection to culture. Lack of access to income, housing, safe housing and the impact it has on terms of their mental health, drug addiction, intergenerational violence. So those are the key things that

> I think caused health inequity, which on the surface is heart disease, diabetes. All those things, but it’s really what’s what’s going on underneath.” (Senior Policy Analyst, Aotearoa New Zealand)

Differential access to goods, services, and opportunities. Participants have shared that the inequitable distribution and access to resources have been a challenge for Pacific Islanders and resulted in disparate outcomes. Even with the promise of parity and equity, systems have failed to deliver. A question was asked of U.S. participants (N=15, 55.6%) about universal health care and their level of agreement that expanding health coverage, such as providing a form of universal health care, would improve health for all. Eight participants “strongly agreed” (N=8, 29.6%), four participants “agreed” (N=4, 14.8%), two were “neutral” (N=2, 7.4%), and one participant “disagreed” (N=1, 3.7%). Participants from New Zealand (N=12, 44.4%) were asked to rate the quality of the response to obligations of te Tiriti o Waitangi. One participant rated the quality to be “excellent” (N=1, 3.7%), four rated the quality to be “good” (N=4, 14.8%), four rated the quality to be “average” (N=4, 14.8%), and three rated the quality to be “poor” (N=3, 11.1%).

During the interviews, participants discussed several examples that demonstrated the discrepancies in access. Participants identified access to transportation, technology, and health insurance as barriers to seeking care or accessing adequate care. They discuss that there is still a long way to go before policies and institutions provide equitable access to resources. A participant from New Zealand expressed a feeling of promises being broken and betrayal of the government for its inability to live up to the Treaty of Waitangi. The participant also draws the connection between the disparities and lack of resources to the health indicators like life expectancy.

> “I mean, I think you can look at almost every step from scheduling an appointment to going to the pharmacy to pick up medications after you’ve seen a provider. Like there are so many challenges that are much more pronounced for patients who don’t have no transportation, WIFI, a device to schedule an appointment on you know, like a lot of the technological advances that should make things easier and leaves a whole category of patients behind who don’t have access to some of those same resources.” (Physician, U.S.)

> “There is still unfair distribution of resources in the system, and although we have improved in terms of historical context, there is still a long way to go in terms making sure that no one is left behind that we are equitable in the distribution of health, of resources and services. To make sure that they are equal opportunities for everyone to you know, find their way in life and progress in development, and so they still have work to be done in terms of policies, institutions, and whatnot.” (Executive Director, Aotearoa New Zealand)

> “Ultimately, New Zealand with the Treaty of Waitangi and there was an agreement between us, and the settler government around how we were going to live, work and be together in this on this piece of it that belongs to us, and though the promises that were made were never kept. So, our access to all of those things that were promised and Article three of the Treaty in terms of being able to have an equitable position alongside

> British citizens was never held up. And so, our access to things like economic success, educational success, access to land and resources, and we think about it in today's terms, like warm dry housing, all of those things that have an effect. We had always been disadvantaged at receiving. And so those things we know all have an impact on how well physically a person can be. So that continues to play itself out in our population and, seeing that we are still dying 7 to 8, 9 to 10 years younger than the rest of the non-Māori population and we say that we're not talking about Pacific Islanders. But you know, pretty much the rest of what we call the other partners in the Treaty relationship. (Consultant and Director, Aotearoa New Zealand)

Bias and Discrimination in Health Services. The lack of social and cultural understanding, cultural competency, and unequal treatment by care professionals and the systems that house them can create negative health outcomes for Pacific Islanders. Many of the examples that participants shared were experiences of implicit and explicit bias and discrimination in the health care setting. Multiple participants cite examples of health providers demonstrating complaints, biases, and prejudices against members of the community. One participant shared that community members were characterized as "non-compliant" due to not attending appointments or not taking medications. These experiences made participants feel unwelcome and resistant to receiving care.

> "They [General Practitioners] will out rightly say, like, 'I've had Māori patients in my practice, and I tell them to do this, and they don't do it, and majority don't do it. They don't listen to my advice so it's a waste of time for me referring them to the specialist.

It's a waste of time for me putting them on the waiting list. It's a waste of time for me giving them the medication. They don't take the medication, so non-compliant.' You know, it's obvious that…we absolutely have that in our system, and I think it's, not just in the doctor's office, it pervades right through the system to the people who hold the funding dollars." (Director and Senior Consultant, Aotearoa New Zealand)

"I've had severe instances of racism or felt like my doctor doesn't listen to me. They don't talk me through those steps, so I don't go to my appointments. And there are studies within Aoteroa about lived experiences of racism within the health system, especially for youth and women. Because doctors treat them like they don't know what's good for them. Huge amounts of judgment, so there's lots of in it could be like, 'I'm isolated, I'm living in a rural community, and I don't have X here, so I can't get a ride.' So there's all these things that are laying under the surface, and there are the causes of the health issue on the surface which our health service does not deliver on, so it's just the upside down model." (Senior Policy Analyst, Aotearoa New Zealand)

"I think in my experience, I want to say it's just like willful negligence on the part of the health care system. Like, "oh, we've never served Marshallese people before with, you know Medicaid eligibility and blah blah blah blah blah…' But I also don't believe that. I think that, there still is bias within individual providers, and when those providers are the ones who set policy and practice for facilities. That can end up, you know unconsciously in the way that people are treated. And so yeah, I'm not going to say it's the most racist place you could go to, but there definitely are incidents where folks go to the hospitals

> and clinics and are treated. Now, there’s a differential in the treatment based on language or race or cultural preference you know to how health care is delivered.” (Chair, Councilmember and Program Manager, U.S.)

Data Challenges and Lack of Representation. Data challenges included data collection practices and policies around collecting data for race/ethnicity and small populations and lack of disaggregated data that have made the certain Pacific Islander population seem invisible. Participants were asked to rate the quality of the data available in the demographic questionnaire to address NHPIs, Māori, and/or Pacific Islander health inequities. Among the participants from the U.S. (N=15, 55.6%), one participant rated the quality of data for NHPIs to be “good” (N=1, 3.7%), five rated “average” (N=5, 18.5%), eight rated “poor” (N=8, 29.6%) and one declined to answer (N=1, 3.7%). Among the participants from Aotearoa New Zealand (N=12, 44.4%), one rated as “excellent” (N=1, 3.7%), five rated “good” (N=5, 18.5%), five rated “average” (N=5, 18.5%) and one rated “poor” (N=1, 3.7%).

Participants identified that lack of representation through data made it challenging to identify and address issues among Pacific Islanders. Most participants expressed being unseen or “lumped together” in the available data. This lack of representation creates an unclear picture of the needs for their community. Others go beyond the lack of representation in the data to discuss the lack of representation in leadership. Some participants specifically called out the makeup of the decision-making bodies as “white-dominated.” Participants shared that there are quite a few members of the community who are in leadership roles but are still operating within a structure dominated by the Western perspective versus an Indigenous or Pacific Islander perspective.

"… Just the way in which data is interpreted, I mean this small numbers … I think data and research practices have just historically rendered us completely invisible. You know you're never going to find what you're not looking for. So, no one knows our history, so no one's asking these questions and so none of that is visible in data and research." (Health Equity Strategist and Executive Director, U.S.)

"There's that issue of data disaggregation…we still get lumped together within the Asian American Pacific Islanders narrative." (Executive Director, Council Member and Professor, U.S.)

"… One of the big issues in New Zealand is collecting ethnicity data, why is it so hard to ask somebody? Apparently, it is. So, we never have accurate figures. They create figures you can't measure. If you can't show, you can't create change. It all tracks back to an inability to say to somebody, 'what's your ethnicity?' So, it just becomes too challenging for the system to keep that going. So, I think that's one of the things is about deficit, it's about how our health inequities are framed, it's something that just happens." (Associate Professor, Aotearoa New Zealand)

"Then there's also the representation piece…I think whether it's the hospitals or the Department of Health, or Government more broadly, we're just not represented in the decision making." (Community Leader and Professor, U.S.)

"I think it comes down to the fact that basically all our decision-making power sits with non-Māori. So they are the ones who are sitting in our management positions. In terms of

> how service delivery, it’s not Māori who are being able to make the decisions for Māori. And basically everything kind of just falls under this umbrella of Western concepts of thinking, and so it’s just not inclusive of a te Ao Māori view, but they likened it to being the norm.” (Senior Policy Analyst, Aotearoa New Zealand)

> “Even when I’ve seen at some of the other leadership tables I’ve sat on. You know, we have all the people represented just one person from each of those [CBOs] But, we’re still primarily white dominated and it’s like, we’re done, we have our melting pot of people who can just share about everything they know about the community. Which you know it’s not true, because we can’t represent every single group. I mean, I know I don’t. I could speak on behalf of the community and advocate for the community and that’s very different than actually saying yes, this is all the groups I represent and why you need to listen to be representative of each of these groups” (Executive Director, Council Member and Professor, U.S.)

Inaction and Maintaining Status Quo of White Supremacy. Participants shared that the continuing disparities among Pacific Islanders are attributed to the inaction of health and social care systems to address their population's needs. Multiple participants perceived that these systems were designed to keep their communities at a disadvantage while continuing to provide privileges to others, most often their white counterparts. One participant draws from the historical policies, and current strategies to address disparities and inequities have not been effective.

“White people, no matter what situation they’re in, they assert their dominance in some shape or form, and that’s not necessarily their fault all the time.” (Director, U.S.)

“So, the idea of race was really the idea of racial capitalism was really about propping up a white supremacist plantation economy in Hawaii, which so those historical roots I see continuing today in a number of ways. But particularly manifesting in the alienation and the continued appropriation of lands and water and how those are sources of health and of power. You know, continue to be held away from Kanaka” (Community Leader and Professor, U.S.)

“…[The] history of white supremacy absolutely affects what our conditions are here. Where it was set up in a way to where they actively want us to be invisible. So, when I come across white folks especially doing health equity work with push back on us, I’m like, ‘No, no, no, no! You’re being complicit to that history if you’re going to use this small numbers excuse…absolutely not!’ And I think that’s important. It’s even within health equity work, there’s just still so much of that dominant culture narrative and we have to push back on that and say, you know that—that’s all by design.” (Health Equity Strategist and Executive Director, U.S.)

“...Even though Māori providers have that lens in, the way Māori see health, it’s still pretty much status quo. We’re still delivering the same types of services as you would have in America. You know, a traditional health model, a western medical health model. Yeah, so

> it’s more inclusive, but pretty much the same.” (Senior Policy Analyst, Aotearoa New Zealand)

> “So, I think we’re still finding out how the racism operates and works, but it’s a system of power that advantages one group disadvantages the other. It can be action or inaction. In our country, it’s informed by settler colonialism and white supremacy.” (Head of Department of Public Health, Aotearoa New Zealand)

> “I think there’s a fear factor, right? I think now what we’re seeing is a fear of certain communities in the U.S. They’re seeing other communities increase in number, increase influence, increase in voice and are amplifying their voice and they’re scared. And now you see the pushback, now you see the rise of white supremacy in all this. Many people were predicting this for years, right? As you were saying, the numbers of minorities go up and the number of you know…and, of course, the fear is also the fear of losing what they’ve acquired, the privilege and the conditions, the advantages that they currently have under this system…” (Professor and Chair, U.S.)

Theme 2: Differing Worldviews and Perspectives of Health

The second major theme that emerged to describe the cause of racial disparities and inequities among Pacific Islanders is the tension between differing worldviews and the Indigenous perspective of health. The Western biomedical model or clinical view of health is the dominant model of care used to resolve many health problems, especially in societies like the U.S and New Zealand. The delivery of care is often focused on the treatment of an individual.

Participants acknowledged that health and wellbeing are more than just the absence of disease and involve more than just the physical or biological aspects. Several sub-themes emerged in which differing worldviews and perspectives of health underscore the importance of culture . The differing worldviews and perspectives on health can create barriers and give rise to the experience of structural racism.

A Holistic Approach. The majority of the participants described that health and wellbeing involve many other dimensions. From a Pacific Islander perspective, the cultural understanding of health embodies a holistic approach. Participants shared that health includes multiple dimensions such as having connections to spirit and culture. A few participants shared that the dimensions of health need to be equally tended to; each has a relationship and is interconnected. Connections are an important aspect of an Indigenous and Pacific Islander worldview. One participant explains the connection through a Māori health model and another from a Native Hawaiian perspective. The holistic approach connects one's health and relationships to the environment, families, communities, and genealogy.

> "…it [health and wellbeing] is really a combination of spiritual, cultural, psychological, and biological factors right that contribute to our health and wellbeing it and where the emphasis lies, I guess, really depends. But I'm a very strong proponent of social and cultural determinants of health." (Professor and Chair, U.S.)

> "As a public health person, I think about the health and wellbeing of communities and populations. As a human, I sometimes think about it as how do you manage yet kind of ill

health... But ideally, it’s about that holistic wellbeing. It’s about being in touch and connected to your wairua, to your spirit, it’s about being able to live gently on the earth. It’s about having a village and being and having able to contribute to the village and in the village that contributes to and enriches your life. It’s about balance. It’s about agency. It’s about making informed choices. Yeah, and it’s about living your values, having the scope to live your values.” (Head of Department of Public Health, Aotearoa New Zealand)

“Well, there’s lots of ways as defined by our systems. But by and large, the system is measured. Its performance is measured against the set of clinical markers, they’re relating to cardiovascular disease, cancer, respiratory illness, and so I guess from one level there’s a very clinical approach to health and well-being in New Zealand. But from a Māori perspective, we use more hauora or wai oranga approach, which is looking more holistically at health and wellbeing.” (Executive Director, Equity and Health Improvement, Aotearoa New Zealand)

“Māori have huge amounts of and it’s mainly within the values, the way that we view the environment is relational. So we work together for the betterment of our environment. We don’t think we know everything and run solo. The concepts of course, kotahitanga, working as one; or whanaungatanga, working as a family; wairuatanga, respecting the history of the land, what has happened there and what’s taken place there knowing who the land belongs to all of that. It’s that worldview.” (Senior Policy Analyst, Aotearoa New Zealand)

> “We use this model called te whare tapa whā, which is four kinds of walls, like the four poles or pillars of a whare [house or shelter]: hinengaro which is the mind, tinana which is your body, wairua which is your spirit, and whānau, your family... you’ve got something like on a whare model, you take one post away it weakens the house…” (Director and Vice President of Public Health Association, Aotearoa New Zealand)

> “…so, he [Dr. Kekuni Blaisdell] talks about, these three piko that connect us with our kūpuna [ancestors], with our present generation, and with future generations. [Piko po‘o] the fontenel, and then your umbilical cord or your piko waeana, your belly button, and then your piko ma‘i, or your genitals. You know that these are connections with those generations. So, he always one, I think, emphasized that health is about these intergenerational relationships. It’s not just about an individual body or being, but it’s in the context of those intergenerational relationships and those piko on our bodies are the physical manifestation of those connections. So, I would say that’s one thing, and then [second] is the connections with ‘āina, that the health of the land and the health of the people, the health of our waters and our bodies are all connected.” (Community Leader and Professor, U.S.)

The dominant model of care does not fully capture the realities and the cultural contexts of Pacific Islanders. There was a consensus of participant responses that inequities and disparities in health among Native Hawaiian, Māori, and Pacific Islanders are due enormously to social determinants of health. Examples include having a job, education, access to care or health insurance, or a home to live in. For example, several participants mentioned living in an overcrowded home or having many people live under one roof. Within the cultural context, participants shared that Pacific Islanders are known to have large, multigenerational families that sometimes live together in one household meant for a single-family. Much of the social, subsidized, or low-income housing units cater to only single families, which is not feasible for many Pacific Islander families. Many participants again alluded to seeing health beyond the individual and put greater emphasis on the collective health of the family and, even more so, the health of the community.

> "In Hawai'i, the number one [issue] is housing, and when I say housing, I don't just mean like you know, having shelter, because that in and of itself is a problem, but also like having enough space. Oftentimes, there's too many generations like crammed into a single-family home, you know. And that has the spillover effects of if you have so many people in one space like, how do you have the privacy to do your homework and to focus and to rebalance yourself? So yeah, I think housing is really important, and also like where that housing is located. As I kind of alluded to, often being super far away from where you have to work or where work that actually pays a decent wage is located..."
> (Policy Analyst and Assistant Professor, U.S.)

> "Yes, I think I've touched on it before, what is significant here in Aotearoa is housing. Right? Is healthy housing in that being top priority because of its impacts on not only just in terms of your health, but also in terms of one's …sorry I'm trying to think of an English word, but in terms of one's hinengaro, in terms of the mentality. And, but also the impact of housing or low housing, I should say, are inadequate to health because there

are a number of homes that are not suitable for the number of people who are actually living within their homes." (Leader, Strategic Projects, Aotearoa New Zealand)

"You know, it's I think to us a lot of it is family oriented, right? Like can you provide for your family? Can you be there for your family? Can you contribute to your family? Are you a burden to your family, right? I think that's a lot of how we view health is not personal, but it's more in a family aspect and what is your role to the family?" (Physician Scientist and Professor, U.S.)

"I think also a worldview that focuses on the collective rather than the individual. You know, it's like, I gotta take care of everybody else in this house first so I gotta take care of everybody in the church. Yeah, I worry about my own health later." (Chair, Councilmember and Program Manager, U.S.)

"..that kaupapa Māori design services are suitable to all in that we do see benefits of that because we don't believe in a one size fits all approach, but we do believe that in terms of well-being is not about the well-being of just the individual or the conditions it does have a wider impact in terms of the whānau, the family… that this is also about the involvement of your whānau family and it's in recognition of all components of what we see in terms of te Āo Māori so environment is considered is a considerable factor as well from that perspective." (Leader, Strategic Projects, Aotearoa New Zealand)

Mistrust. A subtheme that emerged from the discussion of differing worldviews was mistrust expressed among participants. One participant explained that a history of mistrust emerged from colonization. Other participants discussed how mistrust in the community impacts how they view institutions that are supposed to help them. Some are skeptical of how they will be treated, particularly in health care settings like delays in accessing care—contributing to a feedback loop where the mistrust delays care and lead to poor health outcomes.

> “With a history of colonization there's just some level of inherent distrust. And I understand that, I mean, I think that people from communities that have experienced adverse effects of colonization have an inherent level of distrust when they when they come into a clinical setting.” (Physician, U.S.)

> “Major distrust of the medical system or the health system so in terms of the way that Health professionals treat specific people when they go in. The institutional racism sort of plays a part of people not wanting to access services or any mean not presenting until the really, really unwell.” (Manager, Aotearoa New Zealand)

Aim 2b Findings from Key Informant Interviews

Aim 2b focused on exploring the way forward with lessons learned and recommendations for improving Indigenous Pacific Islander health, social outcomes, and health equity. These findings answered research question three, “what is the way forward to improving Indigenous Pacific Islander health and social outcomes and health equity?” Two overlapping major themes have emerged in the analysis: (1) dismantle structural racism and (2) decolonize our health systems. Several subthemes were integrated into the summaries below with extracted quotes from participants

Theme: Dismantle Structural Racism through a Decolonizing Approach

Participants shared ways to address health inequities and advance health equity among Pacific Islander populations. In the demographic questionnaire, participants were asked their level of agreement with the statement, “advancing health equity involves anti-racism and decolonization.” Among the participants (N=27), 23 “strongly agreed” (N=23), two participants “agreed” (N=2), one participant was “neutral” (N=1), and one participant “disagreed” (N=1). The first theme that emerged from the analysis is the need to confront and dismantle structural racism and defuse the forces driving the social and health systems that perpetuate Pacific Islander inequities. The second theme overlaps and works in congruence with the first theme, which incorporates a decolonizing approach to dismantling structural racism. Decolonization was perceived to be a critical approach to centering the concerns and worldviews and coming to know and understand the theory and research from the perspectives of the people and for their own purposes (Smith, 2012). In practice, it is an ongoing process that requires commitment and action to redress historical injustices through contemporary strategies. Below are some examples that emerged as sub-themes shared by the participants.

Acknowledge Racism and Confront Racist Histories. In the demographic questionnaire, participants were asked their level of agreement in whether “it is important to learn about the local historical context, and the diverse ways in which Indigenous people have experienced inequities through time," and 26 participants "strongly agreed" (N=26). One participant "agreed" (N=1).

Participants shared the importance of acknowledging and confronting the historical contexts of racial injustices, such as the adverse effects of colonization and the continuing effects of colonialism. Multiple participants expressed the need to explore counternarratives of historical events to shed the negative light on how the communities are portrayed in the dominant narrative. Other participants have shared the experiences of having conversations about racism in different spaces. Much of this is uncomfortable, but it is imperative to make needed changes

> "I think one of the first things is a recognizes that racism does exist…I think that's one of the biggest things first is recognizing that does exist and it's not in somebody's head…" (Executive Director, U.S.)

> "History is very important. Knowing your history and knowing the right story…" (Community Elder, Operational Governance, Aotearoa New Zealand)

> "History has been a very powerful tool in trying to promote some of the initiatives that we have, especially around foodways and lifestyles and kind of tying in and even birthing practices and pregnancy care by looking back to historical practices. How did our great grandparents do this? and how do those some of those things align well with what clinical guidelines say today and then using Pacific Islander voices who are trusted health professionals themselves to kind of reinforce those messages. We definitely string that in in terms of, ancestral lifeways and foodways and helping people remember how

colonization changed that and now we have reliance on introduced foods and processed foods and that type of thing…” (Chair, Councilmember and Program Manager, U.S.)

“You know, for some of the Pacific jurisdictions some of those events happened, less than a generation ago…and are still happening today. So, I don’t think that the dispossession of land…I think that’s an ongoing thing that is happening currently and it’s not you know, marked by a point in time at which things changed, it’s a continuum. So, it’s really hard to think about undoing that. I think part of the part of the issue, honestly, is still recognizing that that those events happened, and that they adversely affected people, I think that there’s not there’s not widespread recognition of that.” (Executive Director, Council Member and Professor, U.S.)

“People don’t stop and ask like, ‘okay, why, is it that Hawaiians have such high rates of domestic violence or incarceration?’ Right? for years, probably decades. Was it that our narrative was with sick, diseased community people? We at our organization, we’re really clear that’s not where our history starts, our history also does not start in 1778, when Cook or those foreign contacts came, no, no, no, our history started way before. How do we also take control of the narrative? How do we, because again, if people aren’t asking who we are, they’re not willing to know where we come from, what are we are doing…Right now, we can insert ourselves in spaces to share that this is really our story. You guys only caught…the cliff notes version, that started here, but it really started back here when we were this brilliant resilient amazing people, right? And crap happened to us and now we’re at the point where we want to rectify that and how do we rectify it for ourselves because, clearly, we can't anticipate or expect others to rectify it for us." (Executive Director, U.S.)

"So, we'll talk about it [Māori Land Wars] and there's books written about it, but it's only just getting introduced into the curriculum, and even then, there are teachers saying, 'it's too heavy! It's too heavy for young people to know about.' So, there's this continued colonial rhetoric of 'get over it,' you know, just a 'next' sentiment, 'Stop talking about it, move on.' Like, there's this inability to face our history. There's this inability...Actually, there's this desire to move towards this notion of New Zealand, AKA a 'settler colony, One people, one nation' when it is not. It's a whitewashing of, and it's a denial of our experience, and it's a denial of our worldview. In this just denial to and what, a desire to move past all that and just to live in New Zealand, [sense of sarcasm] 'a place of racial bliss...'" (Senior Policy Analyst, Aotearoa New Zealand)

"But it was made key that such history needed to be known and we still debate to the state that there is not enough. It's still not enough for people to understand the history and then it should be a requirement in the education system and that it is not just the requirement for Māori and/or Pacific to know about the history and where colonization has had its affects on Māori. Because what we've learned over time is that, having a better understanding and appreciation, not saying it's a good appreciation, but just saying having an appreciation of what had happened makes it very clear in terms of what you want to avoid from happening…I guess in this part here, that it does require collective voice. That's what we found over time and just having little plots of knowledge, of

> experts around an area is not enough. But, bringing all of those voices into one place, and then actually pulling it across to whether it be to the Crown, whether it to be to others, and in terms of a learning space. You will see that louder voices have more impact, rather than just more individual voices, collectively. Which is part of our history and has always been part of our history as Pacific peoples, as Polynesians." (Leader, Strategic Project, Aotearoa New Zealand)

Education. Participants shared that education can help shape and challenge worldviews, improve competency and literacy, connect to culture, connect to the community, and make decisions. One participant shared that taking the opportunity to teach cultural practices can lead to a healthier community. Education in practice is a valuable tool to inform individuals and the masses and connect people toward collective action. Another participant shared the importance of anti-racist education related to their community. Education closes the gaps in disparities, but it also helps to learn and share strategies to decolonize and dismantle racist systems. A participant from New Zealand describes how education is key to understanding her identity as a Māori woman, which is core to her health and wellbeing.

> "But I think teaching our people, every opportunity we see, we get whatever practices it is in, whether it's limu, catching fish, cooking, making medicine, all of that leads to a healthier community. And it helps, because it goes out, the net gets wider and wider as other people teach each other, and they're really not teaching anything or learning anything. They know 'em. They just forgot…" (Director, U.S.)

“I think we need to do a lot of just education like anti-racist education within our own community. Unfortunately, our community is guilty of like antiblackness racism on so many deep levels. I think part of that is our own colonization. And so, I think there needs to be general education around about racism within our community, and not just like racism against our community but, racism in general. Because I think like a lot of our own folks don’t think that ‘oh, racism doesn’t impact us, that’s a Black issue…’ you know? A lot of our people actually think that and don’t see the ways that racism exists in our daily lives. So, I think we need to do like internal education for our community.” (Project Director, U.S.)

“On education side of it, as somebody that spent a lot of years doing health education for our community, it will be a talking point to encourage our community to utilize their health care and to think about their health, a certain way, so that’s why I say it’s one step because the system will take a step and then on our end we will take steps with our community, to try to move along with the system…” (Project Director, U.S.)

“…incredibly core to my health and wellbeing is my identity as a Māori woman and how I define it. Being able to have access and ability to have conversations and meet people and learn things that helped me to increase my confidence and my own sense of self within as a Māori woman have been really important. So, when I say that education is really, really key, whatever that education looks like, I think to fill myself up with the things that I can then choose to weave my identity together.” (Consultant and Director, Aotearoa New Zealand)

Ground in and align with Indigenous knowledge, values, and culture. In the demographic questionnaire, participants were asked their level of agreement on the statement that “traditional, Indigenous knowledge, values, and culture are important tools and should be incorporated towards improving health equity.” Among the participants (N=27), 24 “strongly agreed” (N=24), and three participants “agreed” (N=3).

Several participants shared the importance of focusing on the social determinants and incorporating the knowledge and values of culture into practice when engaging with communities. One participant shared their experience working with a community organization that centers on Native Hawaiian ways of thinking and how this formed a connection with other groups in the community and shared a collective experience. Another participant describes the cultural value of communal decision-making in their practice and how it is a small but important consideration in their delivery of care.

> “Just thinking about how I have learned so much from participating in their programs or being an observer in the ways that they’re [Local Community Organization] building community and framing health in this really broad kind of way. That really centers how to build relationships of trust and accountability and care among peoples and ‘āina while putting Kanaka Maoli ways of thinking and relating and understanding at the center, but not like in an exclusive way. So, using like a deep grounding in mo‘olelo for example, about Kalihi to be the springboard for or invitation point for others to also share their stories. Rather than just like, ‘well, everybody needs to know this kind of a way.’ Or how they have this Pasifika garden, where they grow plants that are culturally significant to various peoples who live in the community, Hawaiian and different Micronesian folks,

> Filipino, and that becomes a way to share. Like how do the people, how do your people use this plant or in different ways of using it for medicines or cooking or various things like that…" (Community Leader and Professor, U.S.)

> "I did mention one that stands out in my mind in terms of acknowledging the nuances and the differences in the definition of what health is in the overall. You know what is it when someone comes into the hospital that they're really trying to do and what does health actually mean? I think that's a consideration. I think our focus on communal decision making when it comes to care plans and that also goes into how many people show up to sing to you and feed you at the hospital and I think those are considerations. We've run into situations here with physicians where like 'why does that person even need to be here?' Or 'why are they making decisions for my patient?' It's just having to understand that this, there's a family, there's a clan, there's a community around this. It's not, health is not seen as individual." (Chair, Councilmember and Program Manager, U.S.)

Culture, again, presents a different worldview that is not always aligned with the ways the systems and institutions operate. One participant shared the cultural value of "food," which is essential in bringing communities together however was not an approved expense to be supported through their funding mechanisms. Another participant describes the importance of creating space to acknowledge and bring Indigenous knowledge and cultural ways into mainstream practice so that it is representative of the communities that they are intended to serve rather than be tokenized. A few participants have also shared how some of these efforts have been superficial, lacking true grounding and alignment to make any effective impacts, and just to "check a box."

> "We forget that there is that thread of cultural relevance to social determinants of health because I've had conversations with federal agencies and partners who are like 'Well, no, you can't use your federal dollars to buy food…' And it's like, well you understand, culturally, it is a connection. It is part of social determinants because for a community to build trust, to have some understanding that you understand their culture, their community and that you respect that component of eating food is a huge part of that. It is seen as a bringing [people] together it's not just about a nourishment. (Executive Director, U.S.)

> "The Indigenous knowledge that they bring…the value that's placed on there, that's generally not seen as great, as other types of knowledge. And that's something that we're working really hard to change so that people are ameliorated well for their Indigenous knowledge. That they bring into those spaces, that cultural ways of doing and being, are acknowledged in mainstream organizations. So that people can feel safe and have a feeling of wanting to give their knowledge within those organizations…Because what you often see is our people when I'm sure you've seen it working in large mainstream organizations, where they could do really well, but feel undervalued, underpaid, taken advantage of…" (Consultant and Director, Aotearoa New Zealand)

> “All of our health authorities in New Zealand, under our legislation are required to work in partnership with our local tribes under the Treaty of Waitangi. So, when you go and look at what that looks like, it’s three meetings a year for two hours. So, it’s a six-hour relationship. And what happens is the Health Authority calls the tribes in and they say, ‘Hey tribes, we’re doing our Annual Plan, we’d like you to give it a Māori name and we’d like you to write a foreword in Māori with some of your, you know, with headings and sayings…and what do you think is your biggest issue?’ And the Tribes might say, ‘oh you know, it’s mental health’…’Okay, we’ll put that in there, that our priority for Māori is mental health…’ And honestly, that’s about the extent of the relationship. They never tell them what the budget is, they never asked them their opinions on where we should sit. They never include them in the budget cycle, or the planning cycle, or the monitoring, or the performance. They don’t routinely give them data on what’s happening inside the Health Authority. So, you know what the world sees is New Zealand’s health system partners with the tribes, what they don’t see is what their partnership looks like, its superficial.” (Director and Senior Consultant, Aotearoa New Zealand)

> “And it was never meant to last, it was never meant to sustain if you really take an honest assessment of a lot of the projects, programs all of these things that are happening have happened it’s because they’ve had to check a box.” (Executive Director, U.S.)

Leadership, Representation, and Accountability. The lack of representation in leadership roles was described as a barrier that led to the poor health experienced by Pacific Islanders.

Several participants expressed the need to have leaders from their own communities. Many of the decisions made for the community are not representative, and leaders and decision-makers are unable to grasp many of the issues at stake. Participants described what community leadership and representation look like, such as community members who have lived experiences. One participant described that non-Pacific Islanders who have spent time working and learning with the community also could be community leaders as advocates and allies, especially to amplify community voices in spaces where they traditionally do not exist. Participants also shared that responsibility and accountability need to be stated upfront with representation from both sides within a partnership and collaborative spaces.

> "One thing I want to see happen in the future is more Native Hawaiian and Pacific Islanders in from community in these leadership roles. Because I feel like the people who are in there now, sit on their high horses and always have. So, putting people who experience poverty and experienced hardships. You know, in those leadership roles that they're making decisions not because they want to make money, but because they want to see people survive in a healthy way." (Community Leader and Treasurer, U.S.)

> "But I actually think Pacific Islander leadership is really different from dominant culture leadership and that Pacific Islander leadership requires a ton of humility… Like everyone is always putting me in my place" (Health Equity Strategist and Executive Director, U.S.)

> "I say that [leadership] has to be from our own community, because we need to be able to bring our own frameworks to the table and present the needs of our community, in a way

that makes sense for our people. But I also have seen really strong like non-Pacific Islanders who have spent some substantial amount of time working with community, learning from community and can advocate, not as a Pacific Islander but can advocate as themselves. People who have learned from community, right? Because I feel like people who make decisions will hear our voices one way and hear other people's voices advocating for us another way, and both those things can be additive. You know one doesn't have to be over the other, but like as many we can develop, as many people too, that are educated of our community, as much as possible. I favor absolutely like building that from within our community, but I also value building relationships outside our community, so that other people are able to elevate it and amplify our needs. (Project Manager, U.S.)

"I think that there is a leadership gap within the Native Hawaiian community and it kind of pains me to say that, but um. Yeah, I often think about…I think one of the problems that I've seen like specifically is, either the leaders that we have are not comfortable with conflict and you need conflict in order to like grow and to move forward. Or the other thing is, they don't focus enough on developing those around them, those are the two big issues I've seen." (Policy Analyst and Assistant Professor, U.S.)

"For Pacific and Māori, we are in the House, we are co-building our House, we just want to make sure that we have a room in the House, you know not to co-build, and you find that you're out in the yard cutting. Yeah interestingly, you might be aware, that the CEO for Health New Zealand is of Samoan. As I said, we are navigators and that's not only

you know, a testament to the caliber of that person, but also the acumen of the Pacific community. So, representation had been a huge theme in terms of the way that we can shift the system and make change into sort of creating more equitable solutions and it's nice to hear that there is representation within the leadership in these big sectors."
(Executive Director, Aotearoa New Zealand)

"And this is where I can be a little bit controversial, I guess, as well. Both sides need to take responsibility for the quality of the work that's going to happen. And, while the bigger amount of it where it needs to be done by our Treaty partners, there's some accountabilities that our people need to take in terms of the advice that our people are giving to those people who really do hold the balance of power. And that's a very, very challenging place. Because I think so much has changed so quickly in the space and a lot of our people are still very colonized in the way that they think and move. And so, there's no blame there because it's just a consequence of the world that we have been handled. Unfortunately, some of those people need to step out of the way to allow those of us, and I say this with great humility, that are least colonized to be able to drive some of the work that really needs doing. I find it really hard saying that I've never said it before…"
(Consultant and Director, Aotearoa New Zealand)

"But I think it all starts from appointment, the appointment process. So, when we are appointing leaders, we want to make sure that we have good tribal representation on the appointment panels and then we're also asking the leaders at the time of the appointment what's their commitment to Māori health, to Te Tiriti o Waitangi, how equity is building

> the Māori workforce, building the future Māori leadership. You know, that's the time to ask them. Not once they're in the role. But, when they're applying for the role, because the people who then make the commitment to do it, it is much easier to hold them to account. Because you're saying, 'well, this is what you've committed to…'" (Executive Director, Equity and Health Improvement, Aotearoa New Zealand)

> "…it's a service position rather than a power position." (Associate Professor, Aotearoa New Zealand)

Power, Self-Determination, and Succession. Many participants have highlighted the existing power differentials in multiple areas that have contributed to inequities faced by Pacific Islanders. Examples include leadership, funding mechanisms, and community engagement. One participant commented on the importance of self-determination and having the power and autonomy to make decisions. However, the decisions are not explicit to the individual level but rather decisions made for the collective. Māori participants shared that "tino rangatiratanga" and "mana motuhake" characterize their right to sovereignty and self-determination under the Treaty of Waitangi. Lastly, to sustain the community's efforts in the movements to improve health, participants alluded to reclaiming power and self-determination and using the momentum of building the collective voice and investing in the younger generation.

> "…our indigenous knowledge is so rich and there are so many ways that we can integrate that into our work. But there's barely been an opening that allows for us to do it because, like funding structures don't allow for us to have that kind of freedom. Nobody funds

work that’s done in that way. So that’s another piece of like structure that needs to shift. If you’re really about doing equity work, then you need to support our community, by giving us the resources we need to build capacity in the way that we need for ourselves and let us do the work you know so. Because only we can build those pieces into the ways that we do the work.” (Project Director, U.S.)

“The core thing about health and wellbeing is actually power and self-determination for Pacific Islanders…For me it’s like, do folks feel like they have power over their lives, do they feel like they’re able to make the choices that truly reflect what their values and what their own culture is? For me, that’s a really important thing…like the health equity piece really has to include power, right? Decision making power, I think that’s incredibly important. And also, just kind of what the value of our experiences are…Pacific Islander leadership in any form of health equity work is absolutely critical…Do we have the power and the resources and the freedom to make the call on, this is what works best for Pacific Islanders because we know as Pacific Islanders what works best…” (Health Equity Strategist and Executive Director, U.S.)

“I’m all for self-determination. I’m all about it. I think we try and just exude that from every pore. Whatever we can ‘cause I feel like that’s all we have left. You know, like everything was stripped from us slowly. And I think that’s why [community leader] believes in building up self first, you know? Like to see the value you have in yourself creates that sense of self-determination. But you cannot have self-determination if you’re not like paʻa [solid] in who you are, I feel, cause then you waver, right? It’s not guided by what is right. It's guided about that situation you're in and so to me that's not self-determination." (Community Leader and Treasurer, U.S.)

"You know it all doesn't come easy we did have to do a lot of work; we learned a lot of mistakes in terms of thinking that we could do this on our own. We definitely recognize with tino rangatiratanga [sovereignty] is the right of the people, but mana motukahe [autonomy, self-government, self determination] is the is the bigger push. Which is the collective voice, right? Mana motuhake is what we've influenced, mana motuhake is what we had to remind the Crown through Te Tiriti in terms of native version around, and what that actually means. So, we as Māori and collectively want you know, a proper partnership at the table. But also, we as Māori for our various tribal areas, have a right to allow for differences in our areas." (Leader, Strategic Projects, Aotearoa New Zealand)

"…But, when I mentioned education about our future is that we've got a whole wave of young people that have our language and our culture, our connectedness, and that is what's going to get us through the next wave of generational wave, as there are people who will be speaking our language. A lot of my generation don't speak it or can speak a little bit of it. But there is, what will come through in the future that we're doing now is putting a foundation down for our grandchildren, young people to be the leaders of tomorrow." (Community Elder, Operational Governance, Aotearoa New Zealand)

"Our voices from the now will be amplified with the voices that are yet to come. Because we have been making a commitment to ensure that our future generations are aware of

> our history, aware of what we're doing to date. And they will continue to carry this voice, because we will be training them, this is part of the succession. And it is a lot around I mean, although it's a standard tune, this is about succession. Building our leaders when they're young, so that we, we always have this continuous voice happening… the numbers will start increasing and the voices will start getting louder. I think that's been the benefit for the likes of Māori, it is the sharing that we bring to our Pacific brothers and sisters as well. (Manager, Aotearoa New Zealand)

> "I made a committment a long time to go, is if ever a young person had asked me to support them with an endeavor that was related to Indigenous or Māori and Pacific health, that I would endeavor to invest one hour of my time. And so, for me, that's investment in the future or what we say in New Zealand, ngā manukura te āpōpō, tomorrow's leaders. And as leaders, we must have that … investing in our future leaders and putting time and energy and effort, even if it's only one hour. It doesn't matter, you know. It's investing our time, so our future generations will come and do even better things in what we have endeavored to do. And so, investing in tomorrow's leadership and delegating it to tomorrow's leadership, support in tomorrow's leaders, in my view is extremely important part of being a leader." (Executive Director, Equity and Health Improvement, Aotearoa New Zealand)

This chapter provided the results of the data collected and analyzed that addressed the two aims of the study through a document analysis and key informant interviews. The closing chapter will present a discussion of the findings and conclude with limitations and future directions.

CHAPTER 5: Conclusion

Discussion

This exploratory study sought to examine the extent to which the health inequities and disparities experienced by NHPIs in the U.S. and Māori and Pacific peoples in Aotearoa New Zealand are perceived as a result of structural racism. To examine this inquiry, the study applied a mixed methods design to answer the following research questions, (1) "Does the available data identify a pattern of racial disparities and inequities for Native Hawaiian and Pacific Islanders in the United States, and Māori and Pacific people in the New Zealand?" (2) "How does the community perceive the disparities and inequities? And (3) "What is the way forward to improving Indigenous Pacific Islander health and social outcomes and health equity?"

A qualitative review of publicly available reports, scholarly work, strategic plans, public policies, and reported statistics from administrative census registers and databases, health surveillance surveys, and cohort and research studies were aligned with evidence from previous literature. For example, indicators such as life expectancy projections suggest that the health status of NHPIs in the U.S. and Māori and Pacific peoples in Aotearoa New Zealand have improved over time . There was also less than a one-year difference between life expectancy projections for NHPIs and non-Hispanic Whites in the U.S. For Māori and Pacific peoples in New Zealand, life expectancy has also improved over time. However, their life expectancy is still five to eight years less than the European group. Improved life expectancy could be due to the improvements in public health and health service delivery. Life expectancy among NHPIs in the U.S. was higher than that of Māori and Pacific peoples in Aotearoa New Zealand, despite the perceived poor performing healthcare system in the U.S. It was assumed that Māori would have fared better given that New Zealand has a universal health care system and a perceived focused priority on this population to improve health outcomes. However, the findings of this study suggest that is not the case. The current healthcare delivery system in place in Aotearoa New Zealand does not serve the Māori or the Pacific populations well.

The study findings provide evidence of discrepancies in attention to the cultural needs and worldviews around health and wellbeing. In the U.S., healthcare delivery varies at the state level, which may explain the improved life expectancies of NHPIs. For example, most NHPIs live in Hawaiʻi and California, where healthcare is more available due to expanded Medicaid (Medicaid and CHIP Payment Access Commission (MACPAC)). The state of Hawaiʻi's health care system may also fare better since the state population is majority-minority. Hawai'i has the highest racial minority population and the highest total multiracial population compared to the rest of the U.S (Krogstad, 2015). Hawaiʻi may be accustomed to addressing the needs of its diverse population and amenable to incorporating culture-informed care practices. Other indicators varied but were generally poor across the indicators of interest for NHPIs in the U.S. and the Māori and Pacific peoples in New Zealand. Indicators include sociodemographic measures, disease prevalence, mortality rates, insurance rates, and representation in the criminal justice system compared with non-Hispanic White or European groups.

To further understand the patterns illustrated from prior reviewed literature and the enumerated statistics, the context was extracted from a reviewed sample of documents and interpretations made from participants through key informant interviews. Historical context provided evidence to suggest possible explanations for the inequities in health among Indigenous Pacific Islanders in the U.S. and Aotearoa New Zealand. The colonial experiences endured by the Native Hawaiians and Māori were similar, from violent encounters with explorers and settlers who invaded and stripped the population of their cultural practices to the loss of land that eventually rendered them as minorities in their homelands. Pacific Islanders in both the U.S. and New Zealand was purposive to enumerate a small, diverse segment of the population demographically. There are significant challenges to understanding Pacific Islanders and the subgroups separate from the Indigenous Native Hawaiians and Māori. In the U.S., Pacific Islanders are a combined race category with the Native Hawaiians. In Aotearoa New Zealand, Pacific Islanders are separate or grouped as non-Māori. Pacific Islanders are considered "settlers" or immigrants to the U.S. or Aotearoa New Zealand that don't fit within the Indigenous definitions of their settled countries.

The experiences in health and social outcomes of Pacific Islanders were worse off and, at most, equal to those of Native Hawaiians and Māori. The policies, institutions, and systems of governance that were historically created to produce different opportunity structures under racial superiority have produced societal norms around racialized outcomes that have adversely affected the Indigenous and Pacific Islander populations.

Evidence gleaned from the documents and participant interviews points to colonialism as both a historical and ongoing process that continues to disadvantage Indigenous and minority populations. The political and sociocultural contexts were also considered, and the nuances that emerged illustrated the structural forces, describing structural racism as a cause of health inequities and disparities. Participants shared a few examples of ways structural racism is operationalized, such as through colonialism, historical and intergenerational traumas, differential access to goods, services, and opportunities, acts of bias and discrimination, data challenges and the lack of representation, inaction of systems and institutions and maintenance of status quo and white supremacy. The dominant Western frameworks that societies continue to operate on, for example, the biomedical model of health, struggle to contend with the worldviews of Indigenous and Pacific Islanders that underscore the importance of culture, how it can create barriers, and give rise to the experience of structural racism. Health from an Indigenous and Pacific Islander perspective is viewed holistically. The tensions and the mistrust in the dominant worldview contribute to the health inequities and disparities among Pacific Islanders.

The participant interviews also described how to improve Pacific Islander health outcomes and advance health equity. Two overlapping themes emerged as broad and actionable recommendations to dismantle structural racism and incorporate a decolonizing approach. The analysis and perspectives gathered from the interviews provided a few examples of decolonizing approaches and the tools that could be used in practice. The first is to acknowledge racism and confront racist histories, and the second is to leverage the acknowledgment with ongoing education. Critical race theory is a practical educational tool that can be applied to challenge worldviews and build competency in antiracism and health equity work. Other examples shared included focusing on the social determinants while also incorporating the communities' knowledge, values, and cultures. Leadership and representation are also important in dismantling racism, especially in decision-making spaces. Important leadership characteristics include community members with lived experiences, leaders who can be held accountable, and those who can lead with compassion and humility. Having representative leadership allows the communities to reclaim power and self-determination, which are important principles of Indigenous rights. Lastly, to dismantle structural racism, we must invest in and empower the younger leaders to do this work to ensure the vision of health equity is sustained for future and healthier generations.

The premise of this exploratory study was to investigate universal health care as a potential or partial solution to addressing the health inequities and disparities experienced by the NHPI population in the U.S. Dialogues in national policy around healthcare have suggested the idea of universal health care as the panacea to poor health outcomes that disproportionately affect diverse, often underserved populations. New Zealand was identified as a comparable country with universal health care and other social programs that might successfully address health inequities and disparities. This study suggests a broader cause of health inequities and disparities beyond expanding health care coverage. In this study, an applied critical approach examined experiences of Pacific Islanders in the U.S. and Aotearoa New Zealand regarding perceived colonialism as an aspect of structural racism. The continued racialization of Indigenous Pacific Island identities has contributed significantly to their negative health status historically. The manifestations of racism and how they are operationalized create an interplay of cumulative disadvantages that is passed through multiple generations and across the social determinants of health. Aotearoa New Zealand and the U.S. have committed to advancing health equity and have acknowledged racism as a determinant of health. Comparatively, Aotearoa New Zealand appears to be more progressive than the U.S., with its priority focus on Indigenous Māori and Pacific Islanders and its acknowledgment of systemic racism. However, the evidence provided in this study shows that there is much more that needs to be done. Both countries must enhance their commitment to absolving racial injustices and advancing health equity.

A Public Health Reckoning

At the time of this study, racial uprisings and protests were widespread following the subsequent murders of countless Black lives, including Ahmaud Arbery, Breonna Taylor, and George Floyd, due to police violence. Amid the deaths and protests, there was also an ongoing global pandemic caused by COVID-19. Following the deaths and protests, state and local governments across the U.S. have passed declarations that named “Racism as a Public Health Crisis.” Many statements have highlighted how the COVID-19 pandemic and police violence have disproportionately impacted communities of color, highlighting the persisting inequities and disparities. COVID-19, in particular, has had a devastating impact on the Native Hawaiian and Pacific Islander populations. Many U.S. states with large populations of NHPIs reported higher rates of COVID-19 positive cases among the Indigenous peoples of the Pacific than in other racial and ethnic groups (Kaholokula et al., 2020). NHPIs also experienced some of the highest COVID-19 death rates of all racial and ethnic groups in the U.S. (Morey et al., 2020; Penaia et al., 2021). The cause of the disproportionate impact on NHPIs was seen as another added layer to the other health and social issues faced by this population, as presented in the study above. More so, it was the lack of reliable data where NHPIs were grossly underrepresented in the data collection and reporting of COVID-19 (Cha et al., 2021). The result was an overall poor public health response, which stunted the ability to understand the impact of COVID-19 on NHPIs fully. Vaccination efforts for this population were also challenging. Native Hawaiians were disproportionately unvaccinated against COVID-19 due to the underlying mistrust stemming from historical trauma and unresolved conflicts with the community that dates back to the overthrow of the Hawaiian Kingdom.

In the year prior to the pandemic, the Native Hawaiian community protested against the proposed construction of the Thirty Meter Telescope on Mauna Kea, a sacred mountain which reignited the heavy distrust in the U.S. government (Hofschneider, 2021). In the Fall of 2021, an environmental public health crisis ensued when a U.S. Navy Fuel Storage unit leaked fuel and contaminated the local water systems pumped into family homes and surrounding businesses

(Malji et al., 2022). This event also brought even more profound distrust of the U.S. government and the military, which has had a poor record of their presence in Hawai’i.

In Aotearoa New Zealand, the country was able to eliminate COVID-19 transmissions twice through non-pharmaceutical interventions that relied on early decisive reactions from health authorities, efficient surveillance systems, targeted testing strategies, and its strict and aggressive regulations lockdown procedures during the beginning of the pandemic (Robert, 2020). However, despite its early success at the beginning of the pandemic, a delayed vaccine rollout, along with new variants and loosened restrictions, caused a surge in cases. An analysis of New Zealand’s earlier COVID-19 outbreaks showed clear and predictable inequities, such as Māori being 2.5 times more likely to require hospitalizations for COVID-19 infection compared to non-Māori and non-Pacific people (Steyn et al., 2021). COVID-19 was hitting Māori and Pacific communities disproportionately hard. Factors included increased exposure from high proportions of frontline health and border workers, easy transmission within high occupancy, multigenerational housing, and disproportionately high levels of underlying comorbidities, including diabetes and cardiovascular disease (Netzler, 2021). Structural bias and systemic racism were also named the major underlying factors.

The vaccine rollout in New Zealand was criticized for being inequitable. A claim focused on its vaccination strategy was filed against the Crown at the Waitangi Tribunal. The Tribunal found that the government’s decision to reject advice regarding the vaccine rollout from its officials to adopt an age adjustment for Māori, who have a younger population and are more vulnerable to the effects of COVID-19, had breached the Treaty principles of active protection and equity (Waitangi Tribunal, 2021). Frontline and essential workers were among the first to receive their vaccines, followed by those over 65 with underlying health conditions. The age-based priority vaccination strategy placed Māori at a disadvantage because of the lower life expectancies and a younger population. Despite the noted failures of public health and the health systems' focus on Indigenous and Pacific Islanders, participants have shared a few positive experiences from the COVID-19 pandemic. In both the U.S. and Aotearoa New Zealand, the reaction to the failed government response brought together community-based organizations to form coalitions and community-led efforts such as collecting their own disaggregated data, doing contact tracing, hosting testing, and vaccination clinics to control the effects of COVID-19 within their communities. It was after these efforts that attention from government and system entities was given, and resources began to funnel in for the Indigenous and Pacific Islander communities. Below are a few extracted quotes from participants:

> "And it's sad that resources kind of popped up in plentifulness both from federal, state, local, and even some philanthropy groups. But like, do we have to wait for a pandemic to have this happen again? If so, that's a [EXPLETIVE] up system I think you know? We're supposed to be about prevention, right? And I think that is what this pandemic has brought out more on how the system is reactive to be inclusive of all communities." [Co-Lead, U.S.]

> "We had already been doing this without state funding in the months leading up to. We had town halls we had, you know, outreach events. We were organizing testing centers at Polynesian churches and Pacific Islander charter schools, etc." (Chair, Councilmember and Program Manager, U.S.)

“But you know, sometimes during COVID, it has been a lot of unity among this group in combating COVID, so there's some good things about us coming together yeah as a single group because our numbers are small…” (Professor and Chair, U.S.)

“But the others are all addressing this COVID 19 piece, but from a very different lens and what we also did was, I was part of the national response team from Hawaii right, so we were the regional, participating in the national and then from there, the national actually morphed and changed and currently, kind of what was an offshoot was an organization called NAOPO, which is the National Association of Pasifika Organizations. Yeah, so that was an offshoot and so that's what we’ve been doing from COVID.” (Executive Director, U.S.)

“The Pacific Community came together and started opening vaccination centers at the local Churches and at the car parks and you know places where you wouldn't normally. They weren't a health clinic.” (Manager, Aotearoa New Zealand)

“So, on a positive note, what was really amazing to watch at that time was actually Māori were leading in terms of addressing the Community level needs. That they needed to be served, and not just for Māori, but for everybody. So, in terms of coming together and sharing them was amazing health promotion in terms of what to do around COVID in amazing social marketing, around what people needed to know and understand and providing food parcels. Doing those things, that’s what we as Indigenous people do really well. Coming together as communities and making sure that everybody’s taken care of.

> Having a lot of online presence and doing it really, really quickly and really putting other people, you know other groups and putting Ministry-led stuff to shame in so many ways… And so, in that first part of it, it was really positive input to see. And actually, because we did things like mobilize and hit roadblocks and you know manifested our rangatiratanga [self-determination], you know at the time we were able to really look after ourselves really well." (Consultant and Director, Aotearoa New Zealand)

COVID-19 was able to shed light on the resilience of Pacific Islanders and the collective spirit to work together. The pandemic also suggested that elements of structural racism affected the COVID-19 response for Native Hawaiians, Māori, and Pacific Islanders. the inactions. The hope is that experience brings awareness to the strengths and weaknesses of the current public health response mechanisms and the need for an equitable lens. Indigenous and community-led solutions are often overlooked in situations like the pandemic. Solutions and perspectives from the community can inform health policy, practice, and research can empower the larger systems and institutions to be more proactive rather than reactive to meet the needs of vulnerable populations. Mainstream health and social systems need to do better to include the knowledge and voices of the communities when planning and implementation.

Another major event that emerged during the time of this study was the New Zealand Health and Disability System reform. In July 2022, Aotearoa will see a change in its public health and disability systems. The reform is a system overhaul to address the significant and persistent issues in delivering equity for all populations in New Zealand. A review of the Health and Disability System was commissioned to identify areas in which the health system could improve. The result of the review recommended a transformation of the health system into a single, nationwide health service. Essentially, it will be a centralization of the system, beginning with the Ministry of Health and the District Health Boards. The review noted that its current system was too complex and became too difficult to manage, which limited funding and resources and created barriers to the quality and delivery of care (Health and Disability System Review, 2020). See Appendix D for the structural changes in New Zealand's Health and Disability System. One key change that was of interest and related to this study was the creation of a new Māori Health Authority. The establishment of a Māori Health Authority was recommended to address the inequities and improve the effectiveness and overall health outcomes for Māori and recognize the government's obligations to Māori under te Tiriti o Waitangi. Below describes what the new health system will have regarding Māori Health:

- a Māori Health Authority with significant authority to work alongside the Ministry of Health on strategy and policy, and to partner with Health NZ to craft care which better meets the needs of both Māori and other New Zealanders –as well as directly funding and commissioning more kaupapa Māori and te ao Māori-grounded services.

- strengthened Iwi-Māori Partnership Boards to act as an influencing and decision-making voice for iwi and Māori in each locality, so that Te Tiriti partnership operates at every level of the health system.

- much stronger expectations on all health agencies and care providers to deliver better care for Māori and other vulnerable groups who have not historically

> received equitable care or outcomes. (Department of Prime Minister and Cabinet, 2021)

Participants from Aotearoa shared a few of their thoughts and insights on the reform with varying degrees of optimism and skepticism anticipating the system change. Below are a few extracted quotes:

> “What's really interesting at the moment in what's going … there's been a change to the way in which our health system is going to be administered and so it’s going back to a centrally operating system of having what we call the Health Authority or Health New Zealand and then alongside that, is the Māori Health, new Māori Health Authority. And the whole sort of view for that is to demonstrate what it looks like to be working in true Treaty partnership at that central government level in terms of the allocation and monitoring and distribution of resources and in health services.” (Consultant and Director, Aotearoa New Zealand)

> “Maori Health Authority is currently in the process of being put together so by June-July of 2022. Enough of Māori Health Authority will be up and running and there is a specific provider to ensure that there is a Pacific-specific Center as well. So, you're seeing today we’ll sort of look at where are the failings for Pacific, so I guess when we sort of look at what is going on in their space and how we’ll be looking to address those needs. It’s an exciting time in Aotearoa because all the talanoa discussions and actually the concrete bricks and mortar and the funding is all coming through to enable this to happen.

Whereas prior to all, everything prior to this date, it's been part of having a mainstream system that sort of had money taken in a hodgepodge fashion" (Manager, Aotearoa New Zealand)

"So that, should say that the barriers or the fences around inequality should be lowering and for us here in New Zealand if we're talking about health, having a New Zealand Māori Health Authority is definitely a right step in that direction." (Community Elder, Operational Governance, Aotearoa New Zealand)

"It will be premature to say how it will manifest. But in the documentation of what needs to be done, they say some mention of the needs of Pacific people and how we might go about doing that. You know, but we are navigators you know in this part of the world, and we will continue to navigate. You know, the system that we are changing was a system that was put up in place with an intention to improve health and wellbeing of all, especially Māori and Pacific. It has delivered to some degree, but there were gaps in after 20 years we realized that it has not completely delivered what was intended in first place. So, this is part of the ongoing revision of the system, societal systems, to make sure that we deliver. And when you look at it from that angle, one can say that New Zealand is doing well. You know acknowledges publicly the challenges that we face and it's very open about addressing that. In some other places around the world, that is denied. (Manager, Aotearoa New Zealand)

> “We are moving to a new health system reform, where we will have a Māori Health Authority with both policy sitting in commissioning and monitoring capabilities. But again, it’s allocation in terms of spending is quite small and its level of influence and impact is ought to be determined. We also have the Treaty…Te Tiriti o Waitangi and so, if you use that as a marker and what a promise to what it’s actually delivered, we’ve still got a hell of a lot of way to achieve a Te Tiriti based health system for Māori.” (Director and Vice President of Public Health Association, Aotearoa New Zealand)

> “Yeah, so from July, so the idea of having a Māori Health Authority and the way it’s been pitched to us has been a little bit contradictory and the amount of autonomy that’s going to be in that system is not clear. And we know historically that especially Labor governments who want to be seen, to be doing the right thing, and who really try and focus on middle class down to what we could call the deserving poor…So, we know that in the past they’ve made promises about equity and promises about power sharing that at the last minute they dive right back. So, we’re kind of waiting to see how much they’re going to dial it back and one of the ways that they can do that is by making Māori Health Authority accountable to New Zealand Health.” (Associate Professor, Aotearoa New Zealand)

The system changes, and the creation of an independent Māori Health Authority was seen as radical and ambitious. However, it was a much-needed move to address its current health system's failings and bring an equitable lens to Aotearoa New Zealand's public health and health service delivery systems. The outcomes of the reforms and whether the system changes improve

Māori health outcomes and the health of the overall population in Aotearoa New Zealand will be anticipated with cautious optimism.

Contributions and Significance of the Study

This study makes significant contributions to understanding how structural racism may influence many of the patterns of disproportionate and persisting health disparities and inequities. Additionally, the study's application of public health critical race praxis centered on the experiences of Native Hawaiians and Pacific Islanders in the United States and Māori and Pacific peoples in Aotearoa New Zealand. While past research exists on these populations individually, few have conceptualized and applied a comparison of these populations. This study also highlights the Indigenous identities of Pacific Island peoples, the intersection of race, and how they are represented in public health policy, practices, and research. The use of narratives to illustrate and triangulate the various data sources provides descriptions and nuance to explore the understanding of the broader historical, political, and socio-cultural contexts. This analysis shows the depth of experiences, and the different forces that impact Indigenous and Pacific Islander lives. This work adds to the growing research on structural racism as a public health issue and discourses in critical race theory, Indigenous health, Pacific Islander health, and global health.

Limitations

The methodological limitations of this study stem from its exploratory nature, including the sample, sample size, data availability, measurement, and data collection. The purposive sampling of the documents reviewed, and the recruitment of key informant interview participants may appear "biased" but is justified to be a technique widely used in qualitative research. Purposive sampling identifies and selects information-rich cases for the most effective use of limited resources (Palinkas et al., 2015; Patton, 2014). This method involves identifying and selecting sources and individuals that are especially knowledgeable about or experienced with a phenomenon of interest (Creswell & Clark, 2017). For example, the data collected from the interviews provided valuable insights from community leaders who work closely with Pacific Islanders in diverse public health sectors. They described the many ways structural racism is being operationalized in those different sectors in the U.S. and Aotearoa New Zealand. The exploratory nature of this study provides the opportunity to expand on the findings for future, larger studies that will incorporate the voices and perspectives of other groups and disciplines of interest.

The use of secondary data analysis may not have suited the exact purpose or answered the research questions inquired. The use of official statistics extracted from publicly available government data repositories and other data sources may reflect biases, and the measurement mechanisms may have changed over time. The data may not have been representative of the broader population or even comparable between geographic contexts. Not all data is created equal. Data that specifically identify Native Hawaiians and Pacific Islanders (s) and the granular subgroups were not always available or were aggregated with other racial categories (e.g., Asian). Some of the data were not always under the purview of the OMB statistical standards, or many data collection efforts still do not fully employ the minimum standard categories, and the availability of race and ethnicity data, particularly for NHPIs, remains inconsistent. The same went for data collected for Māori and Pacific peoples. Subgroup data for Pacific peoples were extremely limited. In some instances, data for Pacific peoples were aggregated into the non-Māori category.

Creswell maintains that all studies have limitations due to inherent shortcomings and weaknesses (Creswell, 2009). As with most qualitative research, the limitations will be the time-consuming and labor-intensive efforts. The findings are not expected to be representative and generalizable to communities beyond the study populations. This study has the following limitations: it is not generalizable; it is non-experimental; there is a potential for researcher bias; the nature and sensitivity of the subject matter may be exaggerated and, at times, skew some of the data. Quite notable as a limitation is the comparative case study analysis methodology. According to Creswell and Yin, the nature of a case study is that of an empirical inquiry (Creswell, 2009; Yin, 2017). When investigating a contemporary phenomenon in depth and within its real-life context, boundaries between phenomenon and real-life context can be distorted. The selection of these case studies and the researcher's reliance on the data and sources provided in these case studies represent possible limitations (Yin, 2017).

The study was initially proposed to be conducted in person, at least with participants from the U.S. However, due to the ongoing situation with COVID-19, the opportunities for in-person activities such as face-to-face physical interviews with stakeholders and community members were not possible. Engaging with participants virtually was challenging but posed minimal risks to the study, and participants and interviews were conducted uniformly for participants from the U.S. and Aotearoa New Zealand. Other limitations are related to language and cultural concepts. Again, Pacific Islanders are truly diverse, and the use of native languages and concepts was not always easily translated and understood.

Conclusion

NHPIs are a vital part of the American cultural fabric that thoroughly goes unnoticed, blended indiscernibly in the tapestry of society. This study was an opportunity to apply a critical approach to understanding the health experiences of NHPIs as a way to advance efforts in health equity. To advance health equity, we must first recognize the barriers that prevent us from achieving the highest attainable standard of health. These barriers may be similar or different for our NHPIs and other communities and populations across the U.S. This study also had a particular interest in bridging a connection with communities from across the Pacific. The investigation compared the health experiences of the Māori and Pacific people in Aotearoa New Zealand to highlight that health and health equity are global concepts, and the priorities apply to both the U.S. and Aotearoa New Zealand. Both the U.S. and Aotearoa New Zealand have ratified the United Nations Declarations on the Rights of Indigenous People. The recognition of the Pacific Island peoples as Indigenous peoples highlights the shared and collective challenges they face. There needs to be a conscious effort to continue Indigenous people's survival. More work to advance equity for our Indigenous Pacific Islanders and the multitude of challenges they face. The U.S. and Aotearoa New Zealand governments must uphold their commitments to prioritizing these populations. We must be objective in sharing knowledge and ideas beyond our borders and look for examples of how our global counterparts are tackling equity in various areas that affect health and well-being, from poverty to structural racism and colonialism, gender inequality, social and environmental injustice, and human rights.

Future Directions

The findings from this study provided both theoretical and practical approaches to addressing health inequities for Pacific Islanders through dismantling structural racism and decolonizing our health systems. More research is warranted to reckon with the histories of colonization and oppression to understand the extent to which structural racism affects health outcomes and overall wellbeing. How emerging measures of structural racism will be able to meaningfully capture the experiences of colonization and immigration/migration histories is unclear. Future research can address this gap by examining existing measures of structural racism and, if necessary, including new items that address colonization, indigeneity, immigration/migration history, intergenerational and contemporary effects of occupation, and other contextual mechanisms of interest that reflect the lived experiences of NHPIs and other Pacific Peoples. By developing and using a measure of structural racism, informed by critical theory, specifically settler colonial theory (Saito, 2020), public health research can more comprehensively capture the intersectional effects of structural racism in a settler-colonial state i.e., the U.S. Further testing and validation of the measure(s) may be applied to other populations, such as the Māori in Aotearoa New Zealand.

While the focus and findings of this study were not intended to be generalizable, the concepts of inequity and structural racism were explored to highlight the similar patterns faced by other Indigenous populations such as the American Indians and Alaska Natives within the U.S. context other global Indigenous populations. This study can be applicable and of interest to explore the ways structural racism affects other Indigenous populations who have been impacted by colonialism. Other areas of interest for future research are to contribute to developing a framework for dismantling racism and applying decolonizing approaches that would catalyze new methods in public health practice and research. Another area of interest is to examine how the new Māori Health Authority fulfills its objective of establishing a true partnership and evaluating whether the reform produces positive health outcomes and reduces health disparities among Māori and the greater Aotearoa New Zealand population. Only time will tell.

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APPENDICES

Appendix A. Recruitment Emails

INTRODUCTION EMAIL TO PARTICIPATE IN AN EXPLORATORY COMPARATIVE CASE STUDY OF EXAMINING THE FACTORS THAT AFFECT HEALTH AMONG PACIFIC ISLANDERS IN THE U.S. AND NEW ZEALAND (IRB # 4066)

INTRODUCTORY EMAIL TO PROSPECTIVE PARTICIPANTS (U.S.)

Aloha,

My name is a Jake Ryann Sumibcay. I am a doctoral candidate in Public Health at Claremont Graduate University School of Community and Global Health in Southern California.

I am conducting a research project to explore and better understand the factors that affect health, both positively and negatively among the Indigenous Pacific Islander populations of the United States and New Zealand. Using a comparative approach, I am interested in exploring the differences of Indigenous/Pacific Islander health experiences operating in two countries in which Indigenous Pacific and Pacific Islanders are focused public health priority populations, in both the United States (U.S.) and Aotearoa New Zealand. I am also interested in learning about the ways we can improve Indigenous/Pacific Islander health outcomes and advance health equity.

I am seeking to interview leaders and practioners in public health, health, and social services and/or population health sector with at least five years experience in working with the Native Hawaiian and Pacific Islander population to better understand their experiences of health disparities.

The interview should take about an 50-90 minutes of your time and can be conducted in-person or virtually using Zoom. The interview will be set up at your preference and convenience. The interview questions will explore your perceptions on Pacific Islander health disparities and explore the ways to improve health outcomes and equity for these communities. Examples of interview questions include background and demographics and open-ended questions focused on topics such as Pacific Islander health, structural racism, and health equity.

To thank you for your participation in the interview, you will be given a $50 USD gift card.

If you are interested in participating in the study and would like to participate in an interview, please contact me at jake-ryann.sumibcay@cgu.edu or +1 808 [redacted]. Also, if you know of any leaders or practitioners who fit the participant criteria and would be interested in participating in an interview, please feel free to forward this email along with my contact information.

Mahalo nui,

Jake Ryann Sumibcay, MPH
jake-ryann.sumibcay@cgu.edu
Doctoral Candidate, Public Health
Claremont Graduate University
(808) [redacted]

INTRODUCTORY EMAIL TO PROSPECTIVE PARTICIPANTS (NEW ZEALAND)

Aloha,

My name is a Jake Ryann Sumibcay. I am a doctoral candidate in Public Health at Claremont Graduate University School of Community and Global Health in Southern California.

I am conducting a research project to explore and better understand the factors that affect health positively and negatively among the Indigenous Pacific Islander populations of the United States and New Zealand. Using a comparative approach, I am interested in exploring the differences of Indigenous/Pacific Islander health experiences operating in two countries in which Indigenous Pacific and Pacific Islanders are focused public health priority populations, in both the United States (U.S.) and Aotearoa New Zealand. I am also interested in learning about the ways we can improve Indigenous/Pacific Islander health outcomes and advance health equity.

I am seeking to interview leaders and practioners in public health, health, and social services and/or population health sector with at least five years experience in working with the Native Hawaiian and Pacific Islander population to better understand their experiences of health disparities.

The interview should take about an 50-90 minutes of your time and will be conducted virtually using Zoom. The interview will be set up at your convenience. The interview questions will explore your perceptions on Pacific Islander health disparities and explore the ways to improve health outcomes and equity for these communities. Examples of interview questions include background and demographics and open-ended questions focused on topics such as Pacific Islander health, structural racism, and health equity.

To thank you for your participation in the interview, you will be given a $50 (USD) gift card.

If you are interested in participating in the study and would like to participate in a virtual interview, please contact me at jake-ryann.sumibcay@cgu.edu or +1 808 [redacted]. Also, if you know of any leaders or practitioners who fit the participant criteria and would be interested in participating in an interview, please feel free to forward this email along with my contact information.

Mahalo nui,

Jake Ryann Sumibcay, MPH
jake-ryann.sumibcay@cgu.edu
Doctoral Candidate, Public Health
Claremont Graduate University
+1 (808) [redacted]

FOLLOW-UP EMAIL TO PROSPECTIVE PARTICIPANTS (U.S.)

Aloha ________________,

As a doctoral candidate at Claremont Graduate University, I am working on a research project to explore and better understand health disparities of the Indigenous Pacific Islander populations of the United States and New Zealand, thank you for your interest in participating.

To be eligible to participate, you should:

1. Be 18 years or older,
2. Have at least 5 years experience working with Native Hawaiian and/or Pacific Islander populations in public health, health and social services and/or population health sector such as but are not limited to such as but not limited to business, community and human services, criminal justice, education, emergency services, faith, government, law enforcement, media, medical/health services, mental/behavioral health, philanthropy, housing, and transportation.

Are you available within the next few weeks to share your insights through an interview? If you are willing to participate, please let me know your availability (specify dates and time).

The interview should take about an 50 – 90 minutes of your time and can be conducted in-person or virtually using Zoom. The interview will be set up at your preference and convenience. If you elect to do the interview in-person, I will provide you with additional information for a safe interviewing session with a pre-screening and safety procedures. I will also be recording the interview to ensure that my notes are accurate, and all recordings will be deleted at the end of this project.

My goal is to learn about how you interpret the disparities and inequities among the Native Hawaiian and Pacific Islander communities and to explore the ways you envision to improve the health and social outcomes, and advance health equity for these populations Examples of interview questions include background and demographics and open-ended questions focused on topics such as Pacific Islander health, structural racism, and health equity.

To thank you for your participation in the interview, you will be given a $50 (USD) gift card.

The Informed Consent form is attached for your review and gives additional information about the research project. If you agree to participate, please email the signed consent form. A signed copy will be emailed to you for your records.

Please let me know your availability with specific date(s) and time(s). If you have any questions, please feel to contact me with the information below.

Mahalo piha for your time,

Jake Ryann Sumibcay, MPH
jake-ryann.sumibcay@cgu.edu
Doctoral Candidate, Public Health
Claremont Graduate University
(808) [redacted]

FOLLOW-UP EMAIL TO PROSPECTIVE PARTICIPANTS (NEW ZEALAND)

Aloha ________________,

As a doctoral candidate at Claremont Graduate University, I am working on a research project to explore and better understand health disparities of the Indigenous Pacific Islander populations of the United States and New Zealand, thank you for your interest in participating.

To be eligible to participate, you should:

1. Be 18 years or older,
2. Have at least 5 years experience working with Māori and/or Pacific Islander populations in public health, health and social services and/or population health.

Are you available within the next few weeks to share your insights through an interview? If you are willing to participate, please let me know your availability. (Specify dates and time).

The interview should take about an 50 – 90 minutes of your time and will be conducted virtually using Zoom. The interview will be set up at your preference and convenience. I will also be recording the interview to ensure that my notes are accurate, and all recordings will be deleted at the end of this project.

My goal is to learn about how you interpret the disparities and inequities among the Indigenous Pacific and Pacific people communities and to explore the ways you envision to improve the health and social outcomes, and advance health equity for these populations. Examples of interview questions include background and demographics and open-ended questions focused on topics such as Pacific Islander health, structural racism, and health equity.

To thank you for your participation in the interview, you will be given a $50 (USD) gift card.

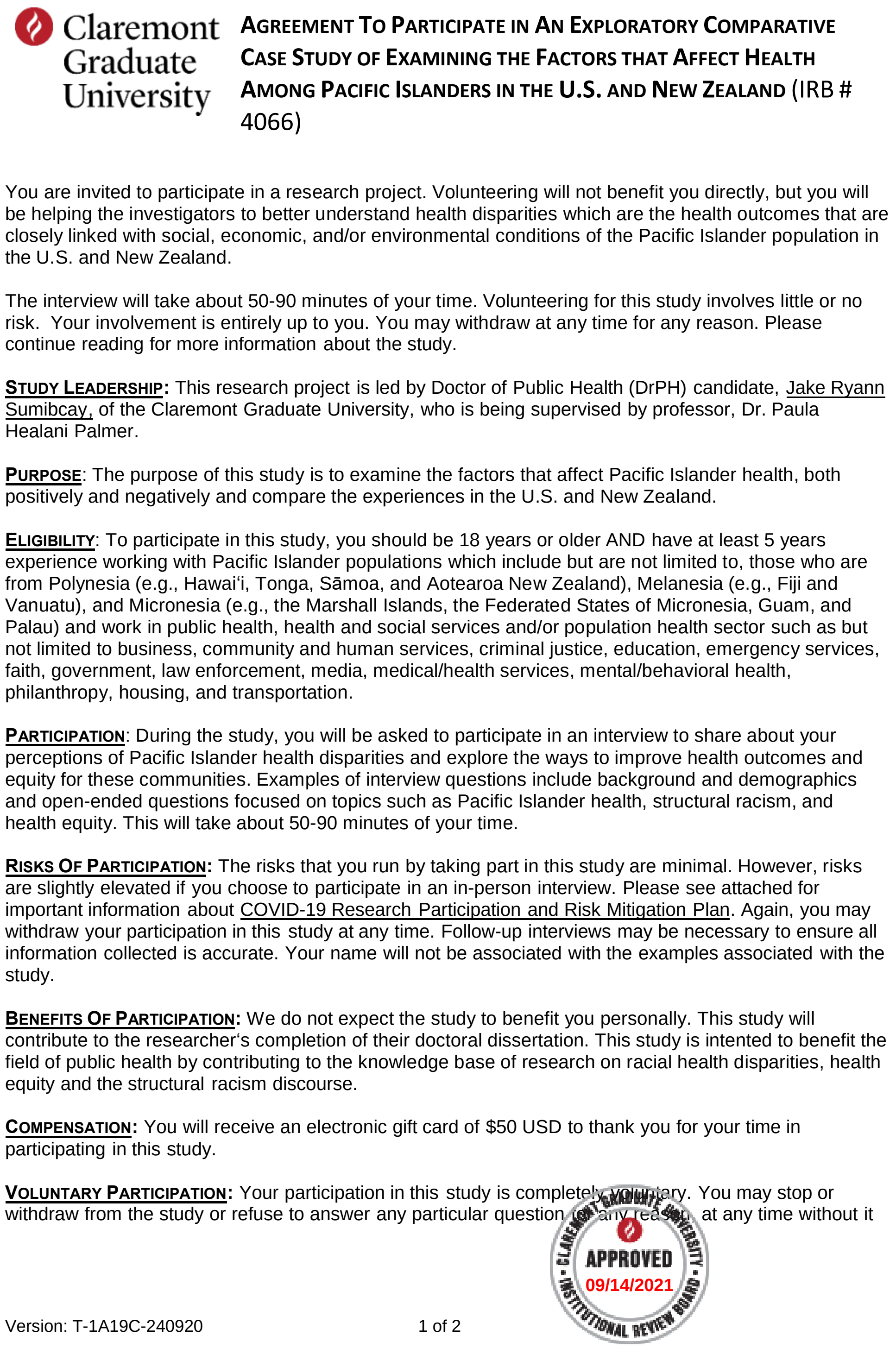
The Informed Consent form is attached for your review and gives additional information about the research project. If you agree to participate, please email the signed consent form. A signed copy will be emailed to you for your records.

Please let me know your availability with specific date(s) and time(s). If you have any questions, please feel to contact me with the information below.

Mahalo piha for your time,

Jake Ryann Sumibcay, MPH
jake-ryann.sumibcay@cgu.edu
Doctoral Candidate, Public Health
Claremont Graduate University
+1 (808) [redacted]

Appendix B. Copy of IRB Approved Consent Form



Claremont Graduate University

AGREEMENT TO PARTICIPATE IN AN EXPLORATORY COMPARATIVE CASE STUDY OF EXAMINING THE FACTORS THAT AFFECT HEALTH AMONG PACIFIC ISLANDERS IN THE U.S. AND NEW ZEALAND (IRB # 4066)

You are invited to participate in a research project. Volunteering will not benefit you directly, but you will be helping the investigators to better understand health disparities which are the health outcomes that are closely linked with social, economic, and/or environmental conditions of the Pacific Islander population in the U.S. and New Zealand.

The interview will take about 50-90 minutes of your time. Volunteering for this study involves little or no risk. Your involvement is entirely up to you. You may withdraw at any time for any reason. Please continue reading for more information about the study.

STUDY LEADERSHIP: This research project is led by Doctor of Public Health (DrPH) candidate, Jake Ryann Sumibcay, of the Claremont Graduate University, who is being supervised by professor, Dr. Paula Healani Palmer.

PURPOSE: The purpose of this study is to examine the factors that affect Pacific Islander health, both positively and negatively and compare the experiences in the U.S. and New Zealand.

ELIGIBILITY: To participate in this study, you should be 18 years or older AND have at least 5 years experience working with Pacific Islander populations which include but are not limited to, those who are from Polynesia (e.g., Hawai'i, Tonga, Sāmoa, and Aotearoa New Zealand), Melanesia (e.g., Fiji and Vanuatu), and Micronesia (e.g., the Marshall Islands, the Federated States of Micronesia, Guam, and Palau) and work in public health, health and social services and/or population health sector such as but not limited to business, community and human services, criminal justice, education, emergency services, faith, government, law enforcement, media, medical/health services, mental/behavioral health, philanthropy, housing, and transportation.

PARTICIPATION: During the study, you will be asked to participate in an interview to share about your perceptions of Pacific Islander health disparities and explore the ways to improve health outcomes and equity for these communities. Examples of interview questions include background and demographics and open-ended questions focused on topics such as Pacific Islander health, structural racism, and health equity. This will take about 50-90 minutes of your time.

RISKS OF PARTICIPATION: The risks that you run by taking part in this study are minimal. However, risks are slightly elevated if you choose to participate in an in-person interview. Please see attached for important information about COVID-19 Research Participation and Risk Mitigation Plan. Again, you may withdraw your participation in this study at any time. Follow-up interviews may be necessary to ensure all information collected is accurate. Your name will not be associated with the examples associated with the study.

BENEFITS OF PARTICIPATION: We do not expect the study to benefit you personally. This study will contribute to the researcher's completion of their doctoral dissertation. This study is intented to benefit the field of public health by contributing to the knowledge base of research on racial health disparities, health equity and the structural racism discourse.

COMPENSATION: You will receive an electronic gift card of $50 USD to thank you for your time in participating in this study.

VOLUNTARY PARTICIPATION: Your participation in this study is completely voluntary. You may stop or withdraw from the study or refuse to answer any particular question (for any reason), at any time without it

APPROVED
09/14/2021

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being held against you. Your decision whether to participate will have no effect on your current or future connection with anyone at CGU.

CONFIDENTIALITY: Your individual privacy will be protected in all papers, books, talks, posts, or stories resulting from this study. We may use the data we collect for future research or share it with other researchers, we will not reveal your identity with it**.** In order to protect the confidentiality of your responses, interviews will be recorded and transcribed and kept on a password protected computer. Recordings will be deleted after they have been transcribed. Any specific information provided throughout the interview which could lead to identification of any individuals will be removed from the transcript.

SPONSORSHIP This study is supported by Health Policy Research Scholars Program, a program of the Robert Wood Johnson Foundation.

FURTHER INFORMATION: If you have any questions or would like additional information about this study, please contact Jake Ryann Sumibcay at jake-ryann.sumibcay@cgu.edu +1-808-206-6462. You may also contact Dr. Paula H. Palmer at paula.palmer@cgu.edu The CGU Institutional Review Board has approved this project. If you have any ethical concerns about this project or about your rights as a human subject in research, you may contact the CGU IRB at +1 909-607-9406 or at irb@cgu.edu A copy of this form will be given to you if you wish to keep it.

CONSENT: Your signature below means that you understand the information on this form, that someone has answered any and all questions you may have about this study, and you voluntarily agree to participate in it.

Signature of Participant ________________________________ Date ___________

Printed Name of Participant ________________________________

The undersigned researcher has reviewed the information in this consent form with the participant and answered any of his or her questions about the study.

Signature of Researcher ________________________________ Date ___________

Printed Name of Researcher ________________________________

09/14/2021

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Demographic Questionnaire – via Qualtrics

Thank you for your interest in participating in a Key Informant Interview.

Please take a moment to complete this pre-interview survey. The questions below will ask about your background/demographics, Pacific Islander health, structural racism, and health equity.

Again, your participation is completely voluntary. You may skip or refuse to answer any particular question for any reason.

This survey is anonymous. Your responses will never be linked to you individually. All identifying information will be omitted in the analysis of the data. NO survey response will be used against individuals, groups, and organizations.

If you have any questions or would like additional information about this study, please contact Jake Ryann Sumibcay at jake-ryann.sumibcay@cgu.edu, +1-808-[redacted]. You may also contact Dr. Paula H. Palmer at paula.palmer@cgu.edu. The CGU Institutional Review Board has approved this project. If you have any ethical concerns about this project or about your rights as a human subject in research, you may contact the CGU IRB at +1 909-607-9406 or at irb@cgu.edu.

You may begin with the first section below.

Section 1A. Background Information

1. Name
2. Email Address
3. Age
4. How would you describe yourself?
    a. Male
    b. Female
    c. Non-binary/Third Gender
    d. Prefer Not to Say
5. Are you a key informant from the United States or New Zealand?
    a. United States
    b. Aotearoa New Zealand
6. What is your highest level of education completed?
    a. Less than high school diploma or equivalent/Levels 1-4
    b. High school Diploma or Equivalent/Levels 5-6
    c. Attended college or Vocational/Trade School
    d. Received an Associate's Degree/Levels 7-8
    e. Received a Bachelor's Degree/Levels 7-8
    f. Received a Mather's Degree or Doctoral Degree/Levels 9-10
    g. Decline to answer
7. Please tell me which one or more of the following do you describe yourself? *Select all that apply*
    a. American Indian/Alaska Native
    b. Asian/Asian American
    c. Black/African American
    d. Hispanic/Latino
    e. White/Caucasia/European/Pakeha
    f. Native Hawaiian
    g. Māori

    h. Pacific Islander, if you identify as Pacific Islander, which subgroup do you identify as:
        i. Carolinian, Charmoru/Chamorro, Chuukese, Kosraean, Marshallese, Palauan, Pohnpeian, Yapese
        ii. Fijian, Papua New Guinean
        iii. Niuean, Samoan, Tokelauan, Tongan
        iv. Other
    i. Middle Eastern/Latin American/African
    j. Other
    k. Don't know/decline

Section 1B: Organization

1. Type of Organization, *select all that apply*
    a. Government
    b. Non-Government
    c. Private Sector
    d. Community-based
    e. Academic
    f. Other
2. What is the primary work of your organization?
    a. Health advocacy/policy
    b. Other advocacy/policy
    c. Planning
    d. Research
    e. Private business
    f. Public sector business
    g. Direct health care/social services
    h. Other direct services
    i. Other, specify:
3. Geographic Region Served
    a. Local
    b. National
    c. Global
4. Select any of the following issues that your organization seeks to address. *Select all that apply.*
    a. Quality/affordable housing
    b. Community safety and violence prevention
    c. Recreation opportunities, parks, and open spaces
    d. Land-use planning
    e. Quality public education
    f. Community economic development
    g. Racial justice
    h. Employment/Workforce/Community Development
    i. Transportation planning
    j. Environmental justice
    k. Food security/access to healthy food
    l. Early childhood development and education
    m. Youth development and leadership
    n. Other, specify:
5. Populations Serve, *select all that apply*
    a. Carolinian, Charmoru/Chamorro, Chuukese, Kosraean, Marshallese, Palauan, Pohnpeian, Yapese
    b. Fijian, Papua New Guinean
    c. Māori, Naïve Hawaiian, Niuean, Samoan, Tokelauan, Tongan
    d. Other, specify:
6. How much does your organization focus on addressing the root causes of health disparities and inequity?
    a. A great deal
    b. A lot

    c. Moderate
    d. Little
    e. None
7. How much does your organization consider the indigenous identities of the populations you serve or work with?
    a. A lot
    b. Moderate
    c. Little
    d. None

Section 2A. US – Native Hawaiian and Pacific Islander Health and Disparities (only if they Select 1A, 5a)

1. In general, how would you rate the **physical and mental health of Native Hawaiian and Pacific Islanders in the US**?
    a. Excellent
    b. Good
    c. Average
    d. Fair
    e. Poor
2. How would you rate **the overall quality of the health care system in the US**?
    a. Excellent
    b. Good
    c. Average
    d. Fair
    e. Poor
3. How much do you agree or disagree with this statement? *Expanding health coverage such as implementing universal health care will improve health for all.*
    a. Strongly agree
    b. Agree
    c. Neither agree nor disagree
    d. Disagree
    e. Strongly disagree
4. MATRIX: I would like you to think about Native Hawaiians and Pacific Islanders in the US, today. Do you think that this population is worse off, just as well off or better as the average white person in terms of:

- Getting needed health care
- Maternal and infant mortality
- Life expectancy
- Housing
- Education
- Employment
- Income
    a. Much worse off
    b. worse off
    c. just as well off
    d. better off
    e. much better off

Section 2B. NZ – Māori and Pacific people Health and Disparities (only if they Select 1A, 5b)

1. In general, how would you rate the **physical and mental health of Māori and Pacific people in Aotearoa New Zealand**?
    a. Excellent
    b. Good
    c. Average
    d. Fair
    e. Poor

2. How would you rate **the overall quality of the health care system in the Aotearoa New Zealand**?
    a. Excellent
    b. Good
    c. Average
    d. Fair
    e. Poor
3. MATRIX: I would like you to think about Māori in Aotearoa New Zealand, today. Do you think that this population is worse off, just as well off or better as the average European person in terms of:
    - Getting needed health care
    - Maternal and infant mortality
    - Life expectancy
    - Housing
    - Education
    - Employment
    - Income
        a. Much worse off
        b. worse off
        c. just as well off
        d. better off
        e. much better off
4. MATRIX: I would like you to think about Pacific people in Aotearoa New Zealand, today. Do you think that this population is worse off, just as well off or better as the average European person in terms of:
    - Getting needed health care
    - Maternal and infant mortality
    - Life expectancy
    - Housing
    - Education
    - Employment
    - Income
        a. Much worse off
        b. worse off
        c. just as well off
        d. better off
        e. much better off

Section 3. Structural Racism

1. MATRIX: How much do you agree with the following statements?
    - *Racism is a public health issue that impacts Native Hawaiian, Māori, Pacific Islander health and wellbeing.*
    - *Racism is a determinant that impacts Native Hawaiian, Māori, Pacific Islander health and wellbeing.*
    - *Differential access to the goods, services, and opportunities of society by race affects the health of Native Hawaiian, Māori, and Pacific Islanders.*
    - *Structural racism exists among Native Hawaiian, Māori, Pacific Islander communities*
        a. Strongly agree
        b. Agree
        c. Neither agree nor disagree
        d. Disagree
        e. Strongly disagree

Section 4. Health Equity

1. MATRIX: In general, how would you rate...in U.S. or Aotearoa New Zealand
    - Focus on health equity
    - Focus on social justice

- The current working being done to address health issues
- The tools, resources, and capacity available to address health issues
- The data available on NHPI or Māori and Pacific peoples
    a. Excellent
    b. Good
    c. Average
    d. Fair
    e. Poor

2. MATRIX: How much do you agree or disagree with the following statements

- Traditional indigenous knowledge, values and culture are important tools and should be incorporated towards improving health equity
- Health and health equity can look different for NHPI or Māori and Pacific peoples
- it is important to learn about the local historical context, and the diverse ways in which Indigenous people have experienced inequities through time
- Advancing health equity involves anti-racism and decolonization
    a. Strongly agree
    b. Agree
    c. Neither agree nor disagree
    d. Disagree
    e. Strongly disagree

3. How would you rate the response to obligations to te Tiriti o Waitangi? **(Only if they Select 1A, 5b)**
    a. Excellent
    b. Good
    c. Average
    d. Fair
    e. Poor

Incentive: To thank you for your participation in the key informant interview, you will be receiving a $50 (USD) electronic gift card or electronic transfer (via PayPal).

Please select the option and provide the following information to ensure the delivery. We will confirm your information again at the end of the interview.

a. An electronic gift card (Amazon)
b. I would like to pay it forward and donate my incentive (Please provide additional information below)

Confirm email address:

Appendix C. Interview Protocol and Guide

AN EXPLORATORY COMPARATIVE CASE STUDY OF EXAMINING THE FACTORS THAT AFFECT HEALTH AMONG PACIFIC ISLANDERS IN THE U.S. AND NEW ZEALAND (IRB # 4066)

KEY INFORMANT INTERVIEW DATA COLLECTION AND INTERVIEW GUIDE PROTOCOL

UNITED STATES

Testing materials

- Audio recording equipment.
- Video Conference Call Platform (e.g., Zoom)
- Email Consent Form and Pre-Survey to participant before interview.
    - Pre-Link: https://cgu.co1.qualtrics.com/jfe/form/SV_eXmLEk6vSLq5Ho2
- Email signed consent form fixed with signatures for participant's record

Research Personnel conducting Interview: Investigator

Procedures for obtaining informed consent

For Virtual Meeting Interviews: Participants will be sent an informed consent form via email prior to the scheduled interview and will be emailed a copy fixed with the signautures for their records.

At start of interview, the investigator will ask if participant has any questions about the consent form and other additional information and if they agree to be interviewed and recorded.

Key Informant Interviews
(Alloted 50-90 minutes total)

Introduction
(Start at _____ end at _____)

Welcome—Explain purpose of the interview
- *Thank you for agreeing to do this interview. My name is JAKE RYANN SUMIBCAY, and I and I will be conducting this interview with you today.*
- *I a 5th year doctoral student studying public health at Claremont Graduate University, School of Community and Global Health in Southern California.*
- *The project is a comparative exploration of the ways we think about equity under a critical Indigenous and Pacific lens.*

- *This project is being funded by the Health Policy Research Scholars Program, a national leadership program supported by the Robert Wood Johnson Foundation to build equity by investing in scholars from populations traditionally underrepresented in graduate programs whose research, connections, and leadership will inform and influence policy toward a Culture of Health.*
- *Thank you for completing the Pre-Survey, did you have any questions or concerns regarding the survey?*
- *In our interview, we will expand on about how you interpret Indigenous and Pacific Islander health disparities and explore the ways to improve health outcomes and equity for these communities. In this interview, we will discuss the context of history, policy, culture, race, and racism and the intersection of health*
- *The interview will last about 50-90 minutes with any additional time provided for follow-up and debriefing.*
- *Did you read the consent form that was sent to you? Do you have any questions?*

[Answer any participant questions, before proceeding to Ground rules]

Ground rules

- *Everything you tell me will be confidential. To protect your privacy, I won't connect your name with anything that you say.*
- *At any time during our conversation, please feel free to let me know if you have any questions or if you would rather not answer any specific question. You can also stop the interview at any time for any reason.*
- *At any time you are uncomfortable or feeling distressed, please let me know.*
- *Please remember that we want to know what you think and feel and that there are no right or wrong answers.*
- *Is it OK if I record this interview today? You have a choice to leave your camera on or off during the interview, but ask to use your audio whenever you are ready to respond.*

[If consented, turn on recording equipment and Press Record]

BACKGROUND/DEMOGRAPHICS/ORGANIZATION

(Start at _____ end at _____)

Thank you again for completing the Pre-Survey.

My first question is:

- Can you introduce yourself and tell me a bit about your work (and this can be in your current position and/or your previous positions) as it relates to addressing health inequities for Native Hawaiians and/or Pacific Islanders?

    - How long or how many years of experience do you have working in public health/health/community?

PACIFIC ISLANDER HEALTH AND DISPARITIES

Next, I would like to ask you more about the health of our Native Hawaiian and/or Pacific Islanders and health disparities?

- In the context of the work that you do, how do you define a health and wellbeing?

Native Hawaiian and Pacific Islanders or NHPI are considered priority populations in the U.S., and while they make up only a small percentage of the national population, evidence shows that these populations experience poorer health comapared the general population across multiple indicators.

- Why do you think that is?

You may share your perspective from the NHPI with in the context of your local community or nationally, whichever you feel comfortable about sharing.

- What are some factors that contribute to the unequal position and disparities of Native Hawaiian and Pacific Islander health?

Health disparities are defined as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

- What would you say are the top critical health issues of Native Hawaiians and Pacific Islander (locally or nationally)? (past, present/ongoing)
    - What has been done to face these issues?

- In your opinion and considering the work that you do, what are your thoughts on the current health system in U.S.?
    - What is the current health system delivery like in your area?
    - What would you say that the current health system is doing well?
    - And what needs to be improved?

The Affordable Health Care Act or Obamacare was a pinnacle health reform to expand health coverage to more people including our NHPI.

Despite gains in getting people insured, we are still seeing these disparities. Health care access was primary indicator in which I seek to compare the U.S. and Aotearoa New Zealand, a country with a Universal Health Care system. We would like to assume a policy like Universal Health Care would eliminate health and racial disparities. However, we see parallels in the disparities among their Māori and Pacific populations.

- What do you think about this push towards Universal access to health care, and would that improve health or reduce disparities and inequities for our populations like NHPI?
- Besides health care access, what other areas that are important to consider improving NHPI health?
- How do we contend to the health of Native Hawaiians and Pacific Islanders who have moved away from the homelands?
    - E.g., Native Hawaiians who have been "priced out of Hawaiʻi" or Pacific Islanders who are Militarized/COFA Migrants? Or Economic Refugees?

[Give short definition of disparity/disparities, if needed]

Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

STRUCTURAL RACISM

Next, I would like to discuss Structural Racism.

Racism/structural racism has been named a public health issue, a determinant that impacts health and well being. It has also been identified as the root cause or fundamental cause of health inequity. In many ways the COVID-19 pandemic has exposed much of the structural inequities, causing disproportionate impact and deepening health burdens across our communities with higher numbers of infection and death especially among our Native Hawaiian and Pacific Islander communities.

- What is the COVID-19 situation and response in your local area and how did it affect the NHPI community?

- How would you describe how structural racism operates in the context Native Hawaiians and Pacific Islanders in the U.S.?
    - What has been the response to address the issues of structural, systemic, institutional racism?(past, present/ongoing)
    - Are the responses effective or is there more that needs to be done?

- Do you think there needs to be greater attention of addressing structural racism?

Structural racism is also view as a system of policies that help drive and perpetuate health inequities.

- Can you identify any specific policies that may have contributed to health inequities among Native Hawaiian and Pacific Islanders in the US?
    - What are some policies that you know has helped improve health or reduce health inequities among Native Hawaiians and Pacific Islanders?

In the context of my project, again I seek to compare the experiences of our Indigenous Pacific Islander health in U.S. and Aotearoa. Our indigenous Pacific populations have consistently been marginalized with their own lands.

I am looking for the a fundamental cause of the perpetuated inequities.

The shared histories of "discovery" and colonization has been the common denominator, which has created a system (a racialized system and a hierarchy of people) that continues to perpetuate and produce racialized inequities embedded in our social, economic and political systems.

We often seen colonialization as a historical thing that has happened in the past

- How would you descibe the connection of history and health that has affected the our Native Hawaiians and/or Pacific Islander ?
    - Do you think that the health disparities and inequities by our Native Hawaiian and Pacific Islander is a result of colonialism?
    - How do the structures of power rooted in colonialism continue to contribute to health inequities?

HEALTH EQUITY AND TOOLS MOVING FORWARD

Next, I want to explore ways that you envision improving Native Hawaiian and/or Pacific health and health equity

***Health equity** means no one is denied the possibility to be healthy for belonging to a group that has historically been socially, economically, and environmentally disadvantaged. I view health equity under the lens of social justice, in which everyone deserves equal privileges in economic, political, and social rights and opportunities.*

- What is your definition of health equity in the context of Native Hawaiians and Pacific Islanders in the US?
- In your role and organization, what has been done to improve health and health equity for Native Hawaiians and Pacific Islanders?

I center this research project holding traditional/indigenous knowledge, values and culture as important tools and should be incorporated towards improving health equity

- What are examples of things that we should when working with Native Hawaiians and Pacific Islanders communities?
    - What has worked and didn‘t?
    - Overall research practice, less-invasive

- what is your view or definition of leadership?
    - Who should be leading?
    - Who should be making the decisions or be part of the decision-making process?

- What are ways to engage the NHPI/Māori and Pacific Islander community and others as well?
    - What are our leaders and organizations getting right about working with/for NHPI?
    - What needs to be improved?

- What do you think are some strategies that can be used to counter structural racism and lead to racial equity?

In policymaking and in any decision-making process, we look towards data to help inform and guide the process

- What sources of data do you utilize and what are examples of the way you use that data?
    - Do we need more data?
    - What are your thoughts on data disaggregation?

- Do you have a vision of equity or equity goals?
    - Who should be involved and who should be accountable
    - What are ways can we push towards anti-racism and decolonialization?

CLOSING AND REFLECTIONS

- Is there anything that we haven't touched upon yet that you would like to add?
- Are there specific people we should be talking to or resources that you would like to recommend that will help inform and expand on our discussion?

Mahalo nui, thank you, for taking the time to share your lessons and expertise with me today.

This information will be very helpful work with leaders and stakeholders to improve health and health equity for our Native Hawaiian, Māori, Pacific Islander communities.

I will now end the recording and welcome the opportunity for a debrief if needed.

[STOP recording and turn off recording equipment] (End at _________)

[Answer any follow-up questions, and respond to any follow-up questions that that participant has]

Provide information on the incentive that they will receive and verify that their information (participant email) to receive the $50 (USD) gift card or payment transfer is correct.

To thank you for your participation in the interview, you will be receiving a $50 (USD) electronic gift card that will be sent to you via email provided. Is this email [email address] correct?

Thank them again for their time and participation in the interview.

Thank you again for your time and participation. If you have any further questions about our session today or about the study, please feel free to contact me.

AN EXPLORATORY COMPARATIVE CASE STUDY OF EXAMINING THE FACTORS THAT AFFECT HEALTH AMONG PACIFIC ISLANDERS IN THE U.S. AND NEW ZEALAND (IRB # 4066)

KEY INFORMANT INTERVIEW DATA COLLECTION AND INTERVIEW GUIDE PROTOCOL

AOTEAROA NEW ZEALAND

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- Video Conference Call Platform (e.g., Zoom)
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    - Pre-Survey Link: https://cgu.co1.qualtrics.com/jfe/form/SV_eXmLEk6vSLq5Ho2
- Email signed consent form fixed with signatures for participant's record

Research Personnel conducting Interview: Investigator

Procedures for obtaining informed consent

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At start of interview, the investigator will ask if participant has any questions about the consent form and other additional information and if they agree to be interviewed and recorded.

Key Informant Interviews

(Alloted 50-90 minutes total)

Introduction

(Start at _____ end at _____)

Welcome—Explain purpose of the interview

- *Thank you for agreeing to do this interview. My name is JAKE RYANN SUMIBCAY, and I and I will be conducting this interview with you today.*
- *I a 5th year doctoral student studying public health at Claremont Graduate University, School of Community and Global Health in Southern California.*
- *The project is a comparative exploration of the ways we think about equity under a critical Indigenous and Pacific lens.*
- *This project is being funded by the Health Policy Research Scholars Program, a national leadership program supported by the Robert Wood Johnson Foundation to build equity by investing in scholars from populations traditionally underrepresented in graduate*

programs whose research, connections, and leadership will inform and influence policy toward a Culture of Health.

- *Thank you for completing the Pre-Survey, did you have any questions or concerns regarding the survey?*
- *In our interview, we will expand on about how you interpret Indigenous and Pacific Islander health disparities and explore the ways to improve health outcomes and equity for these communities. In this interview, we will discuss the context of history, policy, culture, race, and racism and the intersection of health*
- *The interview will last about 50-90 minutes with any additional time provided for follow-up and debriefing.*
- *Did you read the consent form that was sent to you? Do you have any questions?*

[Answer any participant questions, before proceeding to Ground rules]

Ground rules

- *Everything you tell me will be confidential. To protect your privacy, I won't connect your name with anything that you say.*
- *At any time during our conversation, please feel free to let me know if you have any questions or if you would rather not answer any specific question. You can also stop the interview at any time for any reason.*
- *At any time you are uncomfortable or feeling distressed, please let me know.*
- *Please remember that we want to know what you think and feel and that there are no right or wrong answers.*
- *Is it OK if I record this interview today? You have a choice to leave your camera on or off during the interview, but ask to use your audio whenever you are ready to respond.*

[If consented, turn on recording equipment and Press Record]

BACKGROUND/DEMOGRAPHICS/ORGANIZATION

(Start at _____ end at _____)

Thank you again for completing the Pre-Survey.

My first question is:

- Can you please introduce yourself (you are welcome to present your whakapapa [FAH-ka-PAP-ah]), and tell me a bit about your work (this can be in your current position and/or your previous positions you have held, how you came into this work) as it relates to addressing health inequities for Māori and/or Pacific peoples?

PACIFIC ISLANDER HEALTH AND DISPARITIES

Next, I would like to ask you more about Māori and/or Pacific Islander health and health disparities?

My first question is:

- In the context of Aotearoa and/or from a Māori/Pasifika perspective, how would you define health and wellbeing?

From my understanding, Māori and Pacific peoples are considered priority populations in Aotearoa, and that evidence shows that these populations experience poorer health comapared to the general population and most often compared to the European-Whites or Pakeha (PAH-key-AH) Why do you think that is?

- What are some factors that contribute to the unequal position of Māori/Pacific health?
- What would you say are the top critical health issues of Māori and/or Pacific peoples in Aotearoa?
    - past, present, ongoing
    - What has been done to face these issues?

From a global/outside perspective, we often look towards Aotearoa as an example of having a responsive health care system

- In your opinion and considering the work that you do, what are your thoughts on the current health system in Aotearoa?
    - What would you say that the current health system is doing well? And what needs to be improved?

I recently learned that the Health and Disability sector will be changing in New Zealand with new reforms to be more centralized and equitable for all, including the establishment of a Māori Health Authority.

- What are your thoughts on this reform?
    - Do you think this will improve the health of not only the Māori and Pacific peoples but for all populations in Aotearoa?

[Give short definition of disparity/disparities, if needed]

Health disparities are defined as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health, or physical disability; sexual orientation or *gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.*

STRUCTURAL RACISM

Racism/structural racism has been named a public health issue, a determinant that impacts health and well being. It has also been identified as the root cause or fundamental cause of health inequity.

In many ways the COVID-19 pandemic has exposed much of the structural inequities, causing disproportionate impact and deepening health burdens across our communities with higher numbers of infection and death

What is the COVID-19 situation like in Aotearoa?

- How would you describe how strucutural racism operates in the context of Aotearoa New Zealand
- What has been the response to address the issues of structural, systemic, institutional racism? (past, present/ongoing)
- What do you think are ways that Aotearoa has acknowledge racism as a health issues or impacts health and wellbeing?
    - Are the responses effective or is there more that needs to be done?
    - Do you think there needs to be greater attention of addressing structural racism?

Structural racism is also view as a system of policies that help drive and perpetuate health inequities.

- Can you identify any specific policies that may have contributed to health inequities among Māori and/or Pacific people in Aotearoa?
    - What are some policies that you know has helped improve health or reduce health inequities among Māori and/or Pacific peoples?

In the context of my project, again I seek to compare the experiences of our Indigenous Pacific Islander health in U.S. and Aotearoa. Our indigenous Pacific populations have consistently been marginalized with their own lands.

I am looking for the a fundamental cause of the perpetuated inequities.

The shared histories of "discovery" and colonization has been the common denominator, which has created a system (a racialized system and a hierarchy of people) that continues to perpetuate and produce racialized inequities embedded in our social, economic and political systems.

- How would you descibe the connection of history and health that has affected the Māori and/or Pacific peoples?
    - Do you think that the health disparities and inequities experienced Māori and Pacific communities is a result of colonialism?
    - How do the structures of power rooted in colonialism continue to contribute to health inequities?

HEALTH EQUITY AND TOOLS MOVING FORWARD

Next, I want to explore ways that you envision improving Māori and/or Pacific health and health equity

The Ministry's definition of equity is: In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognizes different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

- What is your definition of health equity in the context of Aotearoa, Māori and/or Pacific peoples?
- In your role and organization, what has been done to improve health and health equity for Māori and/or Pacific peoples?

I center this research project holding traditional/indigenous knowledge, values and culture as important tools and should be incorporated towards improving health equity.

- What are examples of things should be considered when working with Māori and/or Pacific communities? What has worked and didn‘t
    - Overall research practice, less-invasive
    - Leadership – what is your view or definition of leadership?
    - Decision-making

- What are ways to engage the NHPI/Māori and Pacific Islander community and others as well?

- What do you think are some strategies that can be used to counter structural racism and lead to racial equity?

In policymaking and in any decision-making process, we look towards data to help inform and guide the process

- What sources of data do you utilize and what are examples of the way you use that data?
- Do we need more data?

- Do you have a vision of equity or equity goals?
    - Who should be involved and who should be accountable
    - What are ways can we push towards anti-racism and decolonialization?

CLOSING AND REFLECTIONS

- Is there anything that we haven't touched upon yet that you would like to add?
- Are there specific people we should be talking to or resources that you would like to recommend that will help inform and expand on our discussion?

Mahalo nui, thank you, for taking the time to share your lessons and expertise with me today.

This information will be very helpful work with leaders and stakeholders to improve health and health equity for our Native Hawaiian, Māori, Pacific Islander communities.

I will now end the recording and welcome the opportunity for a debrief if needed.

[STOP recording and turn off recording equipment] (End at **_________**)

[Answer any follow-up questions, and respond to any follow-up questions that that participant has]

Provide information on the incentive that they will receive and verify that their information (participant email) to receive the $50 (USD) gift card or payment transfer is correct.

To thank you for your participation in the interview, you will be receiving a $50 (USD) electronic gift card that will be sent to you via email provided. Is this email [email address] correct?

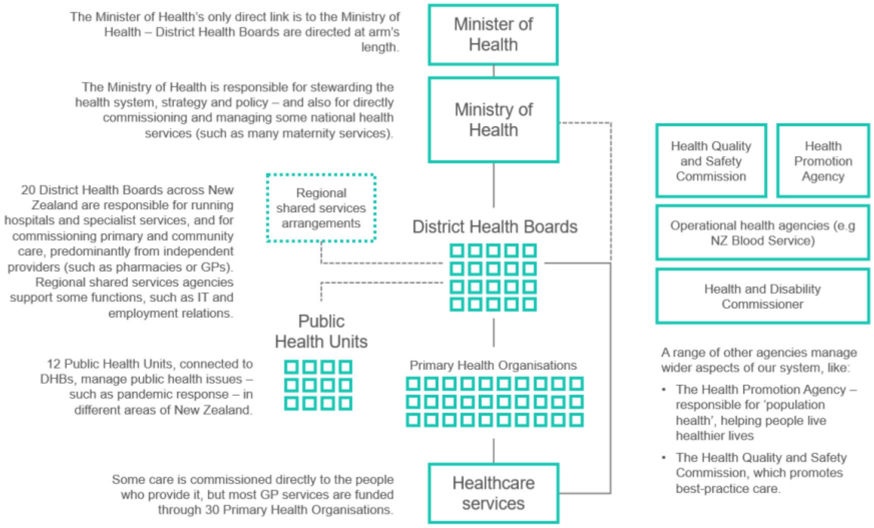
Thank them again for their time and participation in the interview.

Thank you again for your time and participation. If you have any further questions about our session today or about the study, please feel free to contact me.

Appendix D. New Zealand Health Reform – Structural Change

Structural change

Our health system is relatively complex; it involves many organisations, each with their own roles and relationships. But at the highest level, our health system broadly works like this:



The Minister of Health's only direct link is to the Ministry of Health – District Health Boards are directed at arm's length.

The Ministry of Health is responsible for stewarding the health system, strategy and policy – and also for directly commissioning and managing some national health services (such as many maternity services).

20 District Health Boards across New Zealand are responsible for running hospitals and specialist services, and for commissioning primary and community care, predominantly from independent providers (such as pharmacies or GPs). Regional shared services agencies support some functions, such as IT and employment relations.

12 Public Health Units, connected to DHBs, manage public health issues – such as pandemic response – in different areas of New Zealand.

Some care is commissioned directly to the people who provide it, but most GP services are funded through 30 Primary Health Organisations.

A range of other agencies manage wider aspects of our system, like:

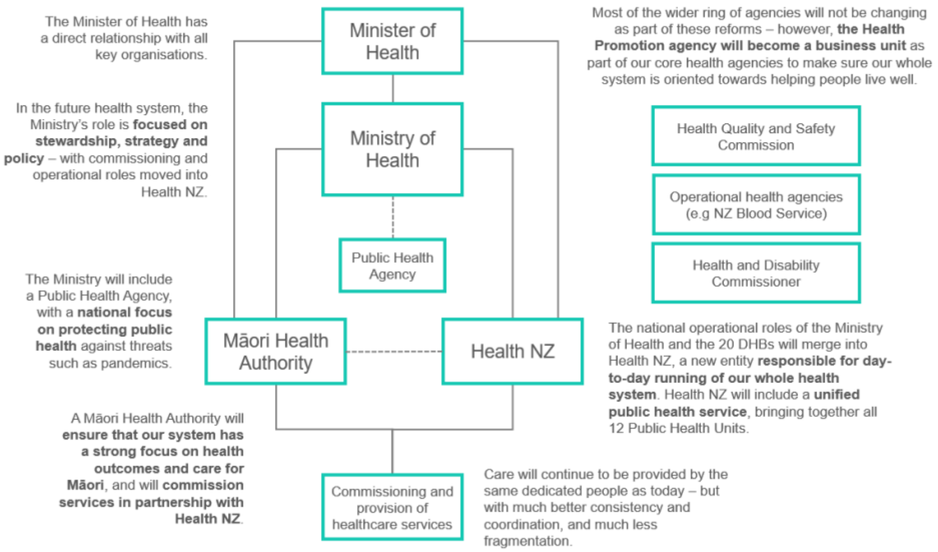
- The Health Promotion Agency – responsible for 'population health', helping people live healthier lives
- The Health Quality and Safety Commission, which promotes best-practice care.

This system is characterised by:

- inequitable outcomes for Māori, Pacific communities, disabled people and others
- limited national planning, so that decisions which could be made once for the whole population are repeated multiple times
- insufficient focus on and investment in primary and community care which helps keep people well and out of hospital
- a 'postcode lottery' which means the care you receive depends on where you live, and which DHB and Primary Health Organisation covers you.

The new structures and organisations being created by these reforms are intended to remedy these problems – and create a consistent, equitable system to provide care to everyone.

Instead of that complex system, the health system of the future will look more like:



The Minister of Health has a direct relationship with all key organisations.

In the future health system, the Ministry's role is **focused on stewardship, strategy and policy** – with commissioning and operational roles moved into Health NZ.

The Ministry will include a Public Health Agency, with a **national focus on protecting public health** against threats such as pandemics.

A Māori Health Authority will **ensure that our system has a strong focus on health outcomes and care for Māori**, and will **commission services in partnership with Health NZ**.

Most of the wider ring of agencies will not be changing as part of these reforms – however, **the Health Promotion agency will become a business unit** as part of our core health agencies to make sure our whole system is oriented towards helping people live well.

The national operational roles of the Ministry of Health and the 20 DHBs will merge into Health NZ, a new entity **responsible for day-to-day running of our whole health system**. Health NZ will include a **unified public health service**, bringing together all 12 Public Health Units.

Care will continue to be provided by the same dedicated people as today – but with much better consistency and coordination, and much less fragmentation.

This system will be simpler and more coordinated, allowing for better and more consistent care. It will tackle the challenges of our current system through several key changes:

- Creating a new organisation, Health NZ, to manage our health system day-to-day. Instead of 20 DHBs, around 30 PHOs and a complex web of contracts, a single Health NZ will be able to ensure simplicity, consistency and quality of care.

- Health NZ will plan and commission health services for the whole population. It will set up four regional divisions and a range of district offices (Population Health and Wellbeing Networks in DHB localities) so decisions are made close to the ground.

- A new Māori Health Authority will have dual responsibilities: it will support the Ministry in shaping system policy and strategy to ensure performance for Māori, and will work in partnership with Health NZ to commission care across New Zealand, ensuring that the needs and expectations of Māori communities are also centred in design and delivery.

- The Ministry of Health will be able to refocus on stewarding the health system and providing advice to Ministers on health strategy and policy – meaning it will be better able to maintain visibility of the health system and New Zealanders' holistic wellbeing.

- The Ministry will host a new Public Health Agency to provide national leadership on public health policy, strategy and intelligence; while Public Health Units will be brought together into a national public health service within Health NZ. This will ensure our Public Health Units are well equipped to respond as one to threats like COVID-19.

- To ensure a focus on keeping people well for longer is embedded in the heart of our health system, the Health Promotion Agency will be merged into Health NZ.

Appendix E. DrPH Competencies

DrPH Competencies Addressed

Data & Analysis

1. Explain qualitative, quantitative, mixed methods and policy analysis research and evaluation methods to address health issues at multiple (individual, group, organization, community, and population) levels
2. Design a qualitative, quantitative, mixed methods, policy analysis or evaluation project to address a public health issue
3. Explain the use and limitations of surveillance systems and national surveys in assessing, monitoring, and evaluating policies and programs and to address a population's health

Leadership Management & Governance

1. Propose strategies for health improvement and elimination of health inequities by organizing stakeholders, including researchers, practitioners, community leaders and other partners
2. Communicate public health science to diverse stakeholders, including individuals at all levels of health literacy, for purposes of influencing behavior and policies
3. Integrate knowledge, approaches, methods, values and potential contributions from multiple professions and systems in addressing public health problems
4. Create organizational change strategies
5. Propose strategies to promote inclusion and equity within public health programs, policies, and systems
6. Assess one's own strengths and weaknesses in leadership capacities, including cultural proficiency
7. Propose human, fiscal, and other resources to achieve a strategic goal
8. Cultivate new resources and revenue streams to achieve a strategic goal

Policy & Programs

1. Integrate knowledge of cultural values and practices in the design of public health policies and programs
2. Deliver training or educational experiences that promote learning in academic, organizational or community settings
3. Use best practice modalities in pedagogical practices

Education and Workforce Development

1. Assess an audience's knowledge and learning needs
2. Deliver training or educational experiences that promote learning in academic, organizational or community settings

Leadership and Management Competencies and Learning Outcomes

1. Critically analyze an issue in health leadership, management or policy and provide recommendations

2. Apply organizational, research, evaluation, or translational methods to adapt, originate, evaluate, or sustain evidence-based health programs or research, strategic planning, or policy to local community, environmental, social, or economic circumstances
3. Provide strategic and operational direction, and guide group-level decision-making
4. Cultivate a shared vision and articulate this vision to diverse groups, stakeholders, and professional collaborators to achieve high standards of performance and accountability

Develop and work with multidisciplinary collaborative teams and partnerships and build capacity and sustainability of individuals, organizations, and communities