Traditional Healing Meeting Modern Health Care Policy

- Culturally Sensitive Health Care Practices for the Indigenous People of Norway and Hawaii:
A Comparison.

Thesis submitted for the
Master Degree in
International Social Welfare and Health Policy

By Anne-Kristine Tischendorf

Fall term 2009

Faculty of Social Sciences
Oslo University College

Acknowledgement

Throughout the work with this thesis there are a many people that have been involved and that deserve my warmest gratitude and appreciation.

It has been a huge step for me to enter into the world of international social welfare and health policy. It was important to me to find a thesis topic where I could somehow remain connected to my long time interest in indigenous cultures and traditional knowledge. To figure out how to approach this research with my newly gained knowledge has been a challenge. I would like to thank my supervisor Michael Seltzer, for assisting me through this process with constructive feedback and for having patience with me and my many shifts in how to approach the research. You and other readers will have to bear over with me exceeding the pages requested - my excitement for the topic is hard to cut back on!

Berit Hetta and Laka Kaohelaulii; I am truly grateful for you contributions, making my thesis less theoretical and more interesting by providing an insight into the indigenous experience. Thank you to Frank Kawaikapuokalani Hewett for having been an inspiration in my life for years! Thank you to Randi Nymo for being willing to share some of your insights at this very busy time for your self - congratulations on you Doctorate! Thank you to all the contributors that assisted with information and guidance! I would also like to express my gratitude to my dear husband on Kauai, Al, who has encouraged me, read the writings from scratch to the end, given constructive feedback and kept the spirit up. Mahalo! Thanks also to Marit for caring to take your time to listen and comment in the process. Last but not least, warm thanks to my son, Fridtjof, for supporting me through the process in your own unique way. Now you know that adults can take more than one afternoon to answer a question and you still have faith in me!

Anne-Kristine Tischendorf
Hønefoss, November 2009.

Abstract

By examining two societies, this thesis has focused on the challenges and problems of the processes involved when traditional healing or folk medicine are incorporated into the margins of the medical system of developed industrialized states. As attitudes are changing, this has motivated a reframing of traditional medicine, actually redefining it from somewhat of an enemy of the medical system to a potential ally. How this is perceived by the traditional healers themselves is reflecting the history of colonialism. By drawing on literature, official documents and informal interviews this paper looks at what has taken place politically, legally and culturally to make traditional medical services available in a professional setting in Norway and Hawaii.

On the question what the similarities and differences are in how the healing practices of the Sami and Native Hawaiians have been incorporated into the dominant health care systems of Norway and the state of Hawaii, several variations are found. This is being reviewed in the light of several major policy shifts by their perspective governments which lead to another area of inquiry: how have the governments of Norway and Hawaii dealt with culturally sensitive health care practises for their indigenous peoples. When looking at Norway and Hawaii, evidence indicates that the health plan with the greatest degree of what is called cultural humility is in Hawaii. One can only speculate why this is so, however, it seems that political activism among Native Hawaiians has not been matched by political activism among Sami in the same area.

In Norway great attention has been given to language and how to provide proper interpretation services, though these efforts are mainly targeted at northern Norway and therefore not accessible to all Sami. Gradually, we can also see institutional efforts to facilitate Sami influence in planning and administration through, per example, creating cooperative organs for communication between departments. In Hawaii, the Native Hawaiians were involved in the planning and development of their health care system from an early stage. Language is given less attention, though still important. Maybe this is so because of the greater need to communicate in a multicultural environment. It is the aspiration of the author to shed light on what areas needs further research for future cultural, political and legal evolution for “culturally humble” health care planning to happen.

Table of contents

1. Introduction

For decades, many within the modern health community viewed traditional healing practices as sub-standard medical care. Primarily due to a lack of evidence based effectiveness, set rules and standards, and no formalized training, industrialized health care professionals dismissed such practices as cultural customs rather than an effect form of health care (Helman, 2007). However, over the years attitudes are changing. Many within the medical establishment now view folk medicine as complimentary. Many major health organizations around the world now view traditional healing methods as a viable asset to overall health care. In many parts of the world, this has motivated a reframing of traditional medicine, actually redefining it from somewhat of an enemy of the medical system to a potential ally[1]. To further illustrate this shift in perception, nations and governments have enacted laws and made changes in constitutions to help bring legitimacy to traditional healers and healing techniques as chronicled by the United Nations Forum on Indigenous Issues' Report of the Secretariat on Indigenous Traditional Knowledge (United Nations, 2007).

While acceptance and perceptions have changed with regard to the integration of traditional healing practices with modern medicine, there still remain many issues that need to be addressed. The World Health Organization (WHO) who's policies recommends the promotion, development and integration of traditional medicine within modern scientific medicine wherever possible, have raised some concerns which include setting standards to ensure safety, quality in the delivery of services and "the potential professionalization of indigenous practitioners is put firmly on the agenda[2].

Ideally these integrative goals demand respect, recognition and collaboration between practitioners of the various systems. For many folk healers, the process of forming a profession has been in response to unequal competition with the medical system. But this challenge they must take on to promote their interests and the interests of their patients. Due to the fact that the numbers of traditional healers in the world today are on the decline, owing among other things to the breakdown of small communities and explosive urbanization, their task is not an easy one. Establishing effective standards, too, is also extremely difficult because traditional healers tend to be a diffuse group and the knowledge and practice of each

[1] Ibid. Helman.
[2] Ibid. Helman:90

individual practitioner often is rooted in the contexts of individual communities.[3] In an effort to help shed light on these issues this paper will examine two societies, focusing on the challenges and problems of the processes involved when traditional healing or folk medicine are incorporated into the margins of the medical system of developed industrialized states.

1.1. Research question

It is against this backdrop that I formulate the central question to be addressed by this thesis. The question is: What are the similarities and differences in how traditional healing practices of the Sami and Native Hawaiians have been incorporated into the dominant health care systems of Norway and the state of Hawaii? Globally the political climates involving minority rights have changed and international conventions of all kinds have emerged to confirm these changes. A growing awareness of and political movements by the Sami and Native Hawaiians is apparent and has required their respective governments to work out policies involving new levels of legal and ethical responsibility. This question will be reviewed in the light of several major policy shifts by their perspective governments which lead to another area of inquiry: how have the governments of Norway and Hawaii dealt with culturally sensitive health care practises for their indigenous peoples? I will attempt to address central issues related to these two questions about policy processes.

1.2. Background for the choice of research topic

My initial interest for writing this paper is rooted in my ongoing relationship to Hawaii and its people. Dating back to 1992, Hawaii has been a source of inspiration and knowledge in my life. In learning about another culture my attention has also been brought back to looking at my own roots and the culture and history of my own society. The binary perspective these experience have provided me has lead me to choose to focus on areas of health policies involving the indigenous peoples of these two societies: Native Hawaiians living in Hawaii, in the middle of the Pacific Ocean, and the Sami of Norway, living close to the Arctic Circle.

1.3. The outline of the thesis

After the methodology section, the main concepts will be clarified in chapter three. In chapter four, a foundation will be laid for better understanding indigenous health believes. Two case examples with informants will be used. Chapter five starts with a description of the two welfare systems being studied and takes the reader into an historic summary of political factors leading into the current health policies for the Sami and Native Hawaiians

[3] Ibid Helman.

respectively. This is followed with material from a seminar and a conference on the heart of the topic. Examples of institutions are presented and two short interviews with indigenous health professionals are given. The discussion follows in chapter 6, looking to answer both questions raised on multiple levels, and then ending with a concluding reflection in chapter 7.

2. Methodology and theories

A comparative study is about observing and comparing similarities and differences in phenomena. According to Halvorsen (2008), one problem with comparative studies across cultures is that the social phenomenon being studied can represent different problems or be interpreted in very different ways in different countries. This is one aspect of the challenges in this paper, the cultural differences between Norway and Hawaii as well as between the worldview of the indigenous healing traditions and the one of the dominant health care system.

2.1. Methods:

The research methods used in this paper focused on how the governments of Norway and the state of Hawaii have interpreted the obligations tied to ratifying or employing international conventions on indigenous rights as well as implemented programs related to culturally sensitive health care delivery services. The primary method for collecting information for this paper was through literature review and governments reports. Since there is no previous study done on comparing these two societies, I was also able to obtain valuable primary data by conducting personal interviews. The interviews varied in approach as I administered semi-structured, informal, conversational interviews via personal meeting, telephone and email. My subjects also were varied in terms of background which added to the depth of the information.

I used a variety of resources to locate articles and information for the research of this paper. While the school library offered a wealth of material, a major vehicle I used to find many of the literature sources was through the internet. I found Google and Google Scholar to give many good results. Searching for material relevant to Hawaii I used the words *traditional healing Hawaii*. Searching *Indigenous People Health Care Hawaii* also brought me information addressing American Natives, Native Alaskans, Aborigines of Australia, Asians and Pacific Islanders. In searching on relevant information for comparison on the Sami population of Northern Norway I used *sami traditional medicine. Tradisjonell samisk healing*

gave a general impression of healers and popular literature on the topic. Knowing that the University of Tromsø is a resource center for Sami studies, I did some searches and discovered that there is specific research performed on this topic at the Senter for Samisk Helseforskning under the University of Tromsø.

2.2. Data

After examining the literature, legal documents and articles, I expanded my focus to see what actually had been done to implement these programs. By personally contacting researchers and other key persons in these areas, my goal was to learn what they had experienced. In my search for access to Ole M. Hetta's article, I decided to contact him directly - not realizing that he is now the senior advisor for Sami social medicine at the Public Health Department. He responded to my telephone call and gave me some very helpful viewpoints, tips and links to official reports on Sami policies. I also contacted Randi Nymo, a Sami woman, registered nurse and teacher who is finishing a doctoral dissertation about Sami worldviews and traditional care systems interacting with public health and welfare systems. I also conducted a brief telephone interview with a research informant working in the field who wants at this time to remain anonymous.

In addition, I have had email correspondence with Randall Sexton, researcher at the University of Tromsø, and Jo Ann Tsark, research director at Native Hawaiian Health Board (Papa Ola Lokahi). They have both been helpful in consulting and supplying relevant material. In Hawaii, I conducted informal interviews with several informants having experience with traditional medicine. Among these were Frank Kawaikapuokalani Hewett, a traditional healer with experience from "cross traditional" collaboration in the health field as the former director of alternative medicine at Waimanalo Health Center. The program assistant, Laka Kaohelaulii, at *Kekukuilamalamaho`ola,* the Native Hawaiian Health Career and Education Program*,* which is part of the Native Hawaiian Health Care System gave information on their program. When I felt I missed more direct experience with the Sami culture, I found it right in my neighbourhood. Berit Hetta became a valuable informant, a Sami woman that has maintained a living in accordance with her cultural roots in the southern part of Norway. These two informants will be used as case examples.

2.3. Theories

It has been stated that "The basic questions of social science today ought not to be whether social inquiry is scientific; rather, it ought to be whether understanding others – particularly others that are different – is possible, and if so, what such understanding involves" (Fay, 2007). This will be a guiding perspective in the analysis and discussion. Further, I will explore the concept of cultural sensitivity, drawing on the theories of Ragnhild Magelsson, a nurse and social anthropologist. Though we tend to most easily notice differences, these differences should not get in the way of seeing the similarities as well. According to Magelssen, this is at the heart of cultural sensitivity where the key is to pay attention to the similarities within the differences (Magelssen, 2008).

Also, I partially used reflexivity theory for examining implications of state policies in relationship to the Sami and Native Hawaiian traditional healing practises. My goal in that respect was to explore and increase understanding of what it might mean to incorporate traditional healing with the dominant health care system. Also discuss, if possible, how incorporation can happen from a philosophical point of view. In this sense, I was often looking at questions involving practices of pre-modernity, modernity and post-modernity.

3. Main concepts, terms and definitions

Since many concepts have many definitions I will devote some space here to clarify my use of the terms. For instance, culture and ethnicity are two closely related concepts with multitudes of definitions and for the purpose of this paper I choose to focus on the cultural aspect. Researching culturally sensitive health care practises and policies, it is necessary to come to grips with the concept of culture itself. "Culture" is not easily defined but as the Norwegian anthropologist Thomas Hylland Eriksen expresses; it could be viewed as central to anthropology as energy is to physics; a concept we cannot manage without (Eriksen, 2002).

3.1. Culture

According to Hylland Eriksen, there are two diverse definitions of culture that can be brought together. The first is historically rooted in tradition and sees culture as "the customs, values and behaviours that are being transferred, though in slightly changing form, from one generation to the next". The other is based on the present, seeing culture as "what makes

communication possible; shared thought patterns, habits and experiences that are the bases for being able to understand each other" (Eriksen, 2002: 60). In bringing these aspects together he argues that cultural processes involve both dimensions of past and present as well as faith and choice. In the first perspective, culture means a deep, inner connectedness and the distillation of generations of wisdom. From the second perspective, culture is a dynamic concept, constantly being created in the totality of the individual but not as part of a universal wholeness as such. What ties these definitions together is our experiences and places us in the junction of past, present and between individuality and the collective of different communities[4].

Magelssen's working definition of culture incorporates a cognitive, affective and a psychomotoric dimension. It includes the knowledge, values and behaviours people internalize as members of society". In this way, Magelssen emphasises that "culture is as much what we look with, as what we look at" (Magelssen, 2008: 15). This goes along with seeing cultural differences, not necessarily tied to ethnical differences. Different cultures are also found between social classes, age groups, regions or urban and rural areas, to mention a few.[5]. This is important to bear in mind since when we discuss indigenous culture, culture as applied to the Sami and Native Hawaiian is a very broad term.

3.2. Culturally sensitive health care

Culture is about thinking, feeling and acting. Cultural sensitivity, then, is to practice less ethnocentrism and apply more cultural relativism. Culture is thus seen as a process, a relational project; "It (culture) is a continual process of change that members of society constantly negotiate" (Magelssen, 2008: 54; personal translation).Cultural sensitivity is then about being aware, knowledge seeking and respectful in that encounter.

There is a general growing attention given to health care providers equipping themselves to meet the needs of an increasingly cross-cultural population. Clearly, health beliefs are found inherent in every ethnic group. A patient's culture, among other factors, influences their beliefs about health and illness. Scholars describe the concept of health as a state of well-being considered desirable in the individual's culture (Kerns et. al, 2003). It also ought to be taken into account that health care provider's personal concepts of health are of great variation as well. Research shows that misunderstanding how a patient defines health can lead

[4] Ibid. Eriksen.
[5] Ibid. Eriksen.

to cross-cultural conflict, broken appointments, abandonment of professional health care, and failure to follow prescribed regimens. Consideration of a patient's definition of health enhances the outcome for the patient and increases both the patient's and the professionals' satisfaction with the office and clinic encounter. (Kerns et.al, 2003, Sexton and Sørlie, 2007, NOU 1995:6)

3.3. Health Care systems

It has to be emphasized that all health care systems have two interrelated aspects, a cultural and a social aspect. Culturally, the aspects are of basic concepts, theories, normative practices and shared models of perception. Socially, the aspects are of the organization of roles like patient/doctor and rules governing the relationships between these roles[6]. The medical anthropologist, Arthur Kleinman, has provided us with a widely used and accepted model of three overlapping and interconnected systems of health care. This involves 1) the popular sector based on self healing with help from family and friends, 2) the folk sector which are made up of unofficial healers including traditional healers and alternative unlicensed practitioners and 3) the professional sector, the licensed practitioners and doctors of bio medicine. Each sector has its own concepts, explanations and set of practises[7]. In most complex societies, including Norway and Hawaii, all three of these can be found. The western health care system with its licensed professionals is the single model in these societies upheld and protected by law. Generally, however, traditional healers in the so-called folk sector have been excluded from this kind of legal support and protection.

From the perspective that every society has its own ethno medicine in how it deals with sickness and healing, biomedicine can be regarded as the ethno medicine of the Western, industrialized world. "As such, it not only arises from this society, it also expresses (and constantly helps recreate) some of its basic cultural premises, including its ways of looking at the world, its social hierarchies and organizations, gender roles and attitudes towards illness and suffering"[8]. The health care systems of both Norway and Hawaii are very much dominated by this Western biomedical cultural view. But as we shall see in the following pages, Norway and Hawaii have, though in different ways, also accepted in principle a commitment to not only respect but also to work with the worldviews, cultural practises and healing traditions of their indigenous populations.

[6] Ibid. Helman.
[7] Ibid. Helman.
[8] Ibid. Helman: 94

3.4. Traditional healing practices

Traditional medicine is also known as indigenous or folk medicine. It comprises medical knowledge systems that developed over centuries within various societies long before the era of modern medicine. The World Health Organization (WHO) defines traditional medicine as:

> *Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.* (http://www.who.int/mediacentre/factsheets/fs134/en/index.html).

These practices and approaches incorporate beliefs and knowledge of plant, animal and mineral-based medicines. Also included are spiritual therapies, manual techniques and exercises. In practice, these are applied singularly or in combination with treatment, diagnose, illnesses prevention and maintaining well-being.

In this thesis, the term *Indigenous traditional knowledge* and *traditional healing* will be used to refer to indigenous peoples' use of traditional practices and the knowledge of plants and animals. This definition includes expressions of cultural values, beliefs, rituals and community laws, and it also includes knowledge regarding land and ecosystem management. In the case of both Sami and Native Hawaiians this traditional knowledge is more often than not unwritten and handed down orally from one generation to the next. I am aware that in translating my limited knowledge and understanding of these concepts and practises into a vocabulary for this paper might not serve it full justice, but I am still hopeful my attempt will bear some fruits.

It is also important to note that what are considered complementary or alternative practices in one country may be considered conventional medical practices in another. In terms of implementation of Traditional medicine (TM) and Complementary/alternative medicine (CAM), WHO's strategy aims to assist countries in both areas equally. It is not within the scope of this paper to discuss Complementary and alternative medicine (CAM), but it is important to be aware of its coexistence and parallel process.

3.5. The Sami and Native Hawaiians – Who are they?

Identifying and classifying indigenous people is a delicate issue, being the social constructions as they are. Classifications are necessary to facilitate laws, trusts, wills and governing programs that target indigenous people. Different government agencies have different methods of classification. For the purpose if this paper, I do not go by one or the other but will share a brief overview of the main definitions and how they also represent challenges:

According to the Act No.56 of 12, June 1987, relating to the Sami Parliament and other Sami legal issues (The Sami Act), a Sami is a person who:

> *- has Sami as his/her first language, or whose father, mother or one of whose grandparents has Sami as their first language, or*
> *- considers himself/herself a Sami and lives in entire accordance with the rules of the Sami society, and who is recognized by the representative Sami body as a Sami, or*
> *- has a father or mother who satisfies the above-mentioned conditions for being a Sami.*

Thus, the everyday use of the Sami language is decisive in determining a person's right to be classified as a Sami and his or her right to vote for representatives to the Sami Parliament or be eligible for election.

It is to be noted, though, that in Norway the Sami people are not one homogenous group but several groups: the costal Sami, the inland Sami, the Lule and the Skolte Sami, the Sami of the north and the south, to mention a few. There is also the Kven, though they are considered a separate minority group. Beside these distinct groups there are also intermarriages that bring in the question of blood quantum. Then there is also the question of culture and identification. Are you raised with Sami language and practices or not? Is your genealogy accessible to you or not? Taking this into account, identifying what a Sami is can clearly be done in different ways for different purposes. These dilemmas are much the same for the Native Hawaiians.

In Hawaii, programs administered by the Hawaii State Department of Hawaiian Homelands are legally bound by trusts to provide services only to Hawaiians claiming at least 50% ancestry back to pre-1778 settlers of the Hawaiian Islands. In the context of the Hawaii Revised Statutes, they have their own definitions as does the Office of Hawaiian Affairs. Both

agencies refer to any person with at least 50% blood quantum to be Native Hawaiian. (www.oha.org, 2009). In practice, however, this distinction is often ignored. Furthermore, the US Census used self defined ethnicity and call the category Native Hawaiian and other Pacific Islanders.

4. Indigenous culture and healing traditions - What is it?

Many questions about indigenous people and indigenous societies can not easily be answered. This is true when it comes to the Sami people and Native Hawaiians, as well. Their traditions have been passed down orally from one generation to the next until more recent time. By giving a brief description of ancient Sami and Native Hawaiian societies, with a special focus on their health and illness beliefs, a foundation is laid from where to discuss the traditional healing practises of the Sami and Native Hawaiians meeting the modern health care system in their respective countries. Two case examples will be used to bring in the perspective of today's society, with a Sami and a Native Hawaiian informant.

"The cognitive world of traditional societies tends to be less compartmentalized than that of the modern Western world", Morley and Wallis write, emphasising how different areas of life are inextricably woven together, both situational and in the thoughts of inhabitants of "technologically less developed societies" (Morley and Wallis, 1978:2). To get a better understanding of traditional medical beliefs and practises one has to grasp the phenomenological and social meanings; focusing on what are the people hoping for and expecting from their medical system. There seems to be certain common trait in the world view of indigenous people relating to health and healing. An ecologic mind and a circular/cyclic time conception are considered as being of outmost importance for the healing process. Religious beliefs and extended family relationships are also very important in indigenous health and disease processes (Hetta, 1986). We see these concepts in both the Sami and the Native Hawaiian societies inspite of the fact that they have developed on different continents under such radically different conditions as the arctic and tropical climate offers.

In searching for information on Sami healing traditions, there was less information available than on Native Hawaiian healing traditions. The information was also more complex to interpret. Several official documents I found gave factual and summarising descriptions. They referred back to many of the same sources. There were slight variations in what was

accentuated in the data but the impression I was left with was that there is not a lot written about Sami traditions and what is documented is external observations or interpretation of unfamiliar phenomenon. The professor and researcher, Jens-Ivar Nergård has spent much time trying to get on the inside of the Sámi culture and give a modern account. His reading is very interesting and helpful to understand many aspects about the Sami society and gives some insight into the use of the healing traditions.

4.1.1. Sami

The Sami region stretches across a large geographical area with cultural and economic variations and therefore also a corresponding diversity in Sami society. The Sami, as "One people" consist, as previously indicated, of many groups inhabiting four different countries. The land of the Sami, called Sápmi, is divided between Norway, Sweden, Finland and the Kola Peninsula, north-western part of Russia. Each country sees its part of Sápmi as its own.

Sami Society

The Sami societies were formerly organized in siidas, which were a form of practical cooperation between several family groups, primarily regarding management and sharing of natural resources and game. The individual siida had a collective right to hunting and fishing within its area. Each siida had a council with a head or leader. The siida served a strong function in socialisation processes, and can be viewed as a Sami cultural bastion (Nergård, 2006)

Similar to the Native Hawaiians, the Sami have developed an economy based on a direct relationship to nature and natural resources. The Sami societies have had a strong integration between production, culture and family. This form of organizing labour required that all women, men and children performed necessary functions. They were all perceived as vital resources for the family and society. Therefore, the socialisation of children was directly associated with the need for knowledge about nature and survival in the arctic climate.

The Sami healing traditions

The Sami living as one with nature had their own healing practises. In literature, these are both referred to as folk medicine practise and shamanism (Altern and Minde, 2000; Nergård, 1994). The view on this has changed over time. And, according to Nergård (1994), by using the word shaman, one has already added something from the external. The words most commonly used among the Sami is noaide. Noaide is referred to as a helper or improver and

is the Sami equivalent of a doctor. Different sources tell of how the Sami used both animal and vegetable products in their folk medicine. Other practices used by the Sami folk healers include bloodletting, "cupping" of tissue fluids, moxa burning which is believed to have roots from China, "reading" of formulas or texts from the Scripture against twist, strain, swivel-eyedness, and also as blood stopping, as well as offering and the use of charms and rituals (Gaski, 1997, NOU 1998: 21, 6.3.22.).

In cases where a diagnosis was uncertain, the noiade sought advice by means of his shamanic drum, or runebommen. The Sami noaide was a person with strong mental and spiritual power. The noaide was capable of transcending states of consciousness and could travel to other spiritual realms to cure sickness or prevent death. The traditional Sami music form yoik and beating on a runebommen contributed to such spiritual travels. The use of yoik has been much misunderstood through historic times and this is probably the reason why the song form was banned when Christianity appeared (St.mld no 55, Polland 1993). The noaide could function as the spiritual head of the siida, in collaboration with the siida-isit/leader. He was considered a strong spiritual leader for his society in moral matters, one that could resolve disputes.

Despite of intense efforts by missionaries, Christianity did not gain a strong foothold north of the polar circle until a revivalist movement spread around 1840 under the leadership of Lars Levi Læstadius. The success of Læstadius may be attributed to how, at a time of strong suppression, it served as a disguise for the Sami nature religion and somehow gave the Sami people a counterforce to the brutalities of the assimilation policies (Nergård, 2006). Sami rituals and ancient practises are still in use today, and, according to Nymo, new practitioners will probably continue to be selected as long as there is demand.

4.1.2. Example: a Sami Woman

When I first contacted the informant, a Sami woman in her 40's, I outlined for her what I wanted to talk with her about, she said: "You know, I am lung sick but since I got my reindeer I have not been sick, ok, I take my medication but I don't need any treatment. Yes, we can have a talk". The next day I met her at her laavo (sami tent) together with her three reindeers in a nearby forest. She was a small and lean woman but very strong. And this is what she shared:

Berit grew up in Kautekeino district in the very north of Norway. She was born into a reindeer herding family, Sami was their first language. It was not until she was 21 years old she really decided to learned Norwegian. She explained, "to teach my head to think differently". This led me to ask what kind of schooling she had had prior. "Ordinary schooling", she replied, which meant boarding school from the age of 7 until 15. In their home environment Sami children were used to the freedom of the mountains. She noted that being locked up in the boarding schools without a choice did not create very good conditions for friendliness.

When Berit's father died her brother took over the herd and she decided for a career in mechanics, took a degree as construction driver and moved to the southern part of Norway. When asking her what it means to her to be Sami she said: "I have never been ashamed to be Sami, never bent my back. I have seen many others do that. Maybe that is one of the positive things the boarding school taught me – never to let anyone step on me." But then she got sick and was hospitalized. "They wrote in the journal that I was a foreigner though I said I'm Norwegian, I'm just Sami", she told me. At first she found this offensive, but it was never corrected and now she thinks it is humorous. It was her conviction, though, that if she had not spoken any Norwegian, the hospital would be less prepared to find her an interpreter than if Arabic, or Urdu her native tongue.

It was at this time she decided to get her own reindeer. "It was an egoistic act", she called it, "I just wanted to come back to the comfort of my childhood memories". And, as she put it, bringing the animals to her in the south became her best therapy. Now she carries 40 kilo bags with feed and pulls 80 kilo of fence wire into the woods and hikes, often for 12 hours, picking forage for her animals. Today Berit is gradually building a business with her three reindeers. She takes people on sledge rides, lectures on Sami culture in different settings and represents on cultural events. But at one time, after getting sick, it was financially were rough for her and her child. She went to the welfare office to ask for some assistance in overcoming a tough period. Berit shared how she was shocked and deeply offended when the case manager had told her that she should slaughter her animals. "I don't ask for help if I don't need it", she said. "If I slaughtered the animals, not only would I take away my very livelihood but I would also kill what means the most to me!" So Berit managed, with the help of her family in

the north, pointing out one major difference between the Norwegian and Sami culture, the importance of family. Then she said; "Six months later I heard that the case manager got sick – she got sick, you know, so that she could learn what it is like – you don't mess with people!"

I also wanted to ask her about her knowledge of traditional healing. By then I had picked up that her sensitivity was well developed and that her perception of the outside world was mistrustful. When I posed my question, she looked away before she replied. She was a child when she, while playing, discovered she had a gift. By imitating what she had witnessed her father doing, she healed her girlfriend's bruise over night. Later she had experiences stopping blood with her focused prayer but this was not something she liked to talk about. "You want to help" she said about herself. "But you cannot help everyone – not the ones resisting". She indicated that the base for helping others, beside the desire to do so, is justice and goodness. "I speak in Sami but I don't pray to the devil." Her challenge, though, is that she picks up the symptoms of the ones she helps. If she need help herself she has "one up north" to turn to. What takes place between them is built on trust over a long, long time. "One doesn't charge money to help", she said. "But to give a gift is different - to find joy in gifting back". "In the north there are long distances and people were forced to find remedies and solutions with the resources they had at hand or could find in nature - but how healers have been punished and executed for their practises, just like witch burning, is still strong in the system. We have learned well to keep it hidden."

The aspect of traditional healing being hidden is not unique to the Sami. But the traditional Sami healing practitioners do operate in less visible ways and are somewhat secretive to the uninitiated. This fact is confirmed both according to my informant, Nymo, historic data, articles and recent research (Nergård 1994 & 2006; St.mld no 55; Sexton & Sørlie, 2007).

4.1.3. Native Hawaiians

In the traditional Hawaiian worldview all things have life, all things have value, and all things are related in a complex genealogy of the world, much like we have seen with the Sami. The fundamental Hawaiian belief is that balance is needed for things to be right. This is based on

the concept of *pono* - the proper relationships and balance between their cosmology, the gods, the environment, and all living beings (Blaisdell, 1991).

It is possible to divide traditional Hawaiian medicine history into three distinct periods: First, the pre-Western era. Secondly, the period of Western contact and cultural conflict with the introduction of diseases and foreign ways following the illegal U.S. armed invasion in 1893 and, 5 year later, the U.S. forced annexation of Hawaii. And last, the modern period of further de-Hawaiianization and coercive, Western assimilation. This went up to the 1985, when an interest in and support for the traditional healing practises re-awoke[9].

Native Hawaiian society

Much like the Sami, each Native Hawaiian learned from early childhood to be self-sufficient living off of the land and the sea. They would also share with others in the geographical units (ahupua'a) they belonged to, extending from the ocean to the inland mountain ridge. But unlike the Sami who were nomads, Native Hawaiians were islanders and each island was ruled by a separate chief or king until King Kamehamea I, in 1810, had united all the island (Mrantz, 1974). Even today, their royal heritage is very important to the Native Hawaiians.

Native Hawaiian Healing Traditions

In pre-Western Hawaii, traditional medicine was organized locally to meet local needs. Harmony (Pono) was maintained by proper thoughts, feelings and actions toward the spiritual as well as the material world. Misfortune or illness was believed to result from altered pono or impaired relationships and loss of spiritual energy. Wellness would thereby be restored by correcting impaired relationships through communication with spiritual forces and healing thoughts and actions. If the individual's efforts at healing were not effective, the intervention of family elder's ('ohana) was sought. If this, too, was not of benefit, the problem was taken to the kahuna lapa'au (medical practitioner-priest), though this could only be done if the patient's status and resources were sufficient[10]. The kahuna can be seen as serving much the same function as that of the Sami Noaide

Interestingly, according to Blaisdell, in all of Polynesia it was only in Hawai'i were there healing temples with a rigorous 20 year curriculum for students to become masters of healing.

[9] Ibid. Blaisdell
[10] Ibid. Blaisdell.

Students would learn to research and perform treatments that students in the western training also spend years specialising in; like simple surgery, fracture-setting, clyster enema, thermo-helio-therapy, induction of pregnancy and baby-delivery, child care, and massage. They also learned the use of medicinal plants including special practices, such as cultivation, gathering and preparation of medicines close observation, how to call and engage spiritual forces and engaging adverse and counter-adverse forces. The most well known traditional healing practises in use today are ho'olomilomi (massage), la'au lapa'au (herb medicine) and Ho'oponopono (counselling and meditation to resolve conflict) (Hilgenkamp and Pescaia, 2003).

The traditional Hawaiian concept of wellness is incorporated in *pono*. In order for a person to have proper wellness all aspects of life had, and still have, to be in balance; the physical, the environmental, the spiritual, the emotional, the social, the interpersonal all have to be properly attended to (Blaisdell, 1991; Hilgenkamp & Pescaia, 2003). It is natural to Native Hawaiians to think that because of their holistic approach to wellness, when balance was disrupted through the collapse of the Hawaiian way of life, Hawaiians became more vulnerable to all sorts of illnesses, both physical, mental, emotional as well as spiritual.

4.1.4. Example: a Native Hawaiian Woman

On Kauai, I met with Laka who agreed to do a personal interview. Laka is from a small town on "the beautiful island of Kauai". She got certified Medical Receptionist at a local Community College and is presently employed with one of the Health Care Systems in the state of Hawaii. On asking her what it mean to her to be Native Hawaiian in today's society she responded:

> *"I am proud of my heritage to see the language and culture being revived not just in the public schools, immersion schools, but the University and colleges as well. Native Hawaiians have been suppressed for many years. Our native language was not allowed to be spoken in public or private schools after the overthrow of the Hawaiian Kingdom, and English became the primary language. But it wasn't until 1978 that Hawaiian was allowed to be taught in the public schools. It's extraordinary to see other ethnicities engulfing themselves in the study of our culture and language. When growing up it was extremely hard especially during the plantation days because in my classroom the focus was on other students and not the Native Hawaiians. Most of my*

teachers were elderly and had no patience for the Hawaiian students because they were considered slow at learning but were rated high in hands on projects. It's fantastic to see the hula, culture, language become alive again."

Since health insurance system in Hawaii is different from in Norway I asked how Laka was insured. *"I have dual insurance coverage and don't see a problem there until I retire", she responded.* And where would she go if she got sick and needed medical help - could it be called culturally sensitive care? She would go to her primary care physician when sick and he monitors her twice a year for chronic conditions since Native Hawaiians has the highest percentage of chronic illness in the state. *"I don't believe he is culturally sensitive but provides me with the best of care. However, my physician does not practice native medicine therefore all medications prescribed are western medicine".* Would you have liked your health care services to be culturally sensitive? *"Not necessarily, but the best of care is important to me. In this way I believe every culture is important".* What does culturally sensitive health care mean to you, in Native Hawaiian terms? "*I guess for me would be someone that has the stats on Native Hawaiian chronic illnesses, a physician that can share appropriate Hawaiian diets, a physician that can share native Hawaiian medicine."*

Are any of the Hawaiian healing practises meaningful to you, in the sense that you would want to use them? "*Yes all, you can't use one without the other. You need to cleanse your soul, make things right, forgive when necessary, the massage that keeps your body align and the medicine to cleanse your body, take out the toxins. When I was younger my Mom used some native medicine on me and some of them were nasty. I'd use it again, except my Mom did not pass it on to anyone, because of the western medicine."*

5. Findings

What I have found in this research is how the Native Hawaiians have actually achieved legal rights and protection for the practice of traditional healing in the state of Hawaii. While in Norway, according to my data as well as my informant, no such cooperation is formally established. In the documents I have read it has remained a subject for "further research" for

more than 10 years. I will present and discuss some factors that seem to influence this fact but also look more closely at what has been done.

5.1. Health care history and welfare models

The two societies in comparison are both considered developed democracies with developed health care and welfare systems. Since I refer to these systems in Norway and Hawaii as the dominant health care systems, I will look at what traits they have in common and how they differ. Structured diversity is an approach to critically compare welfare states (Kennett, 2004). Becoming acquainted with the respective welfare regimes of Norway and Hawaii will express something about within which framework, the traditional healing practices are seeking incorporation. Since history reveals information that help put the development in perspective, the following is a brief description of the welfare models and an exploration of the policy history in relationship to the Sami in Norway and the Native Hawaiians in Hawaii :

5.1.1. Norwegian welfare system

Norway represents a social democratic welfare regime (Esping-Andersen, 1990) with a state funded universal health care system in place. One important step towards universal coverage for welfare services and expenses was the introduction of the National Insurance Scheme (NIS) in 1967. The NIS is a public universal insurance scheme that assures everybody a minimum of social security, regardless of income. It was administrated by the National Insurance Administration until the latest NAV-reform in 2006, where the three agencies: the Labour Market Administration (Aetat), the National Insurance Service (Trygdeetaten) and the Municipal Social Welfare Service (Sosialkontoret), established a joint front-line to better meet users' overall needs for assistance (Johnsen, 2006).The Nav-offices provide a gateway to the employment and welfare services to all citizens. It offers a range of services for the unemployed and enterprises, people on sick leave, disability pensioners, people who receive financial social assistance, and pensions and family benefits.

The Norwegian health system is a tax-based system that covers all inhabitants. It is built on the principle of providing equal access to services for all inhabitants, regardless of their social and economic status, and location. To fulfil this aim, the structure is organized on three levels that mirror the political tiers: the central state, five health regions, and the 431 municipalities. Local governments draw on local taxes and a mixture of block grants and specific allocations (earmarks) from the national government in order to cover their expenditure. In addition to

funding, the central government also provides legislation and supervision to ensure that the services offered by local government comply with the national goals. The idea behind the decentralized health system was bringing the politics of health care closer to the users and to encourage inhabitants to take part in local politics[11].

The European Observatory on Health Care and Policies have issued a report: "Health Systems in Transition" (HiT). According to the report the normative aspects of the citizens' rights for health care in Norway are expressed in the Patients' Rights Act. The goal as outlined is "to secure the population equal access to health care of good quality". The law also sets limits for what falls inside the guarantee offered by the law: the citizen's right is only valid if the patient has an expected benefit from the health service, and the costs are in proportion to the effect of the intervention. The law does not prioritize different diagnoses and/or health status. It was noticed in the HiT report that the principle of equality of access is supplied with a priority for interventions that affect health status or health improvement[12].

5.1.2. Hawaiian welfare system

The U.S. can be described as a liberal welfare regime (Esping-Andersen, 1990), in the sense that it represents individualism, laissez-faire, residualism and a punitive view of poverty. Since the US does not have a unified welfare system, many important functions are held by the states, including public assistance, social care and various health schemes. As the 50th state in the U.S., Hawaii is one of a few states that have state-funded health systems.

By comparison with other developed countries and in particular Norway, the central government in the US has had a limited role in social welfare provision. The main developments of federal provision were during the Roosevelt administration of the 1930s, which laid the foundations for the social security system, and the "War on Poverty" of the 1960s, which provided some important benefits such as health care for people on low incomes (Fitzpartick, 2006). In practice one could say that the US is pluralistic, rather than liberal. There are significant departures from the residual model - e.g. state schooling, social insurance, or the Veterans' Administration and Medicare for those over 65 years, which provides health care for nearly 40 million people. In addition to federal and state activity, there are extensive private, mutualist and corporate interests in welfare provision.

[11] Ibid. Johnsen
[12] Ibid. Johnsen

Hawaii had a tradition of something similar to universal health care during the 1800 and 1900's. At that time, large plantations provided hospitals and physicians care for their vast workforces (Tabrah, 2008). This changed drastically around the time of World War II. Later, in the 1960's there was much discussion at the national level in the US about the provision of compulsory national health insurance. Prepaid Health Care (PHCA) was considered at the time to be the most feasible plan to provide prepaid health care to employees under the age of 65. When the development of the PHCA started in 1973, legislators in Hawaii were faced with many of the same issues and concerns faced today by the Obama government: rising health care costs, limited access to health insurance and services for some, and Hawaii's economic concerns, among others (Aira, 2008). The PHCA was met with significant legal challenges at the time. The result of this is that the PHCA is frozen in time and does not account for market fluctuations, changes in the Hawaii economy, and costs of health care. Nonetheless, according to the Hawaii Uninsured Project, the PHCA continues to play a significant role in Hawaii's health care system. In addition to the employer mandate under the 1974 PHCA, Hawaii has the so-called QUEST program (Johnsen and Linstad, 2003), a Medicaid-waiver project with a safety net for low-income people who don't qualify for Medicaid.

5.1.3. Pre- WWII history and assimilation politics.

From around the middle of the 1800's, the Norwegian authorities, at the time an independent state but in forced union under the Swedish throne, imposed a strict policy of forced assimilation on the Sámi people and national minorities. The union with Sweden dissolved in 1905 but the nationalist wave lingered on. The "Norwegianization" policy eventually moved into other social spheres. Following language, it became dominant in agricultural policies, defence, education, communications and media. For instance the Land Act of 1902 stipulated that property could only be transferred to Norwegian citizens and furthermore only to those who could speak, read and write Norwegian (samediggi.no). It was not until the 1930s that Sami was again allowed as a secondary language in some school districts to augment teaching. In practice, the Sami language was banned in many Norwegian schools well into the 1950's (Dallmann, 2009). The Sami of today are considered among the most modernized indigenous people in the world (Gaski, 1997). The use of modern technology in reindeer herding is but one example.

Throughout the history of Hawaiian health, the arrival of Captain Cook in 1778 and the introduction of infectious and communicable diseases stand out as an incontestable assault on Hawaiians and the Hawaiian way of life. It continued with the arrival of Protestant missionaries in 1820 at which time the Hawaiian population had radically declined in less than a generation. By the end of the 18th century and a steady stream of foreign visitors from the East and West, the traditional healing and knowledge could not stem this devastating tide and the Native Hawaiians had entered a process sometimes referred to as "cultural trauma" brought on by forced assimilation (www.oha.no). In 1848, this trend continued with the land division known as the *mahele* which destroyed traditional Hawaiian land tenure and made the majority of Hawaiians landless. The overthrow of Queen Liliuokalani in 1893, at which time the Hawaiian population had dwindled to 40,000, was another serious blow to the indigenous population with huge ramifications socially and politically. At this time, Hawaii was "ruled" by plantation owners and commercial interests. In regards to this comes an interesting difference to the Sami experience; the importation of immigrant workers. These people, mostly from Asia, but for the fact of curiosity, also 600 from Norway (Greipsland, 2004) adds to the complexity of Hawaii as a multi cultural society with multiple assimilation processes going on simultaneously.

According to Minde, a strong assimilation policy has been part of any strong nation building process, whether in Norway, America or elsewhere. The assimilation politics went through several faces over the years. Though, in Norway, little attention was given to Sami issues during the interwar period and the postwar reconstruction, a new line of official thought began to split away from conscious assimilation. After World War II a new "spirit of the times", tied in with the UN's Human Rights Declaration of 1948 which embraced a political consciousness about cultural equality, saw light internationally (Kymlica, 2007; Dallman, 1997).

This led the way and in 1956, the Ministry of Church and Education appointed a committee to examine Sámi issues. The committee's report, completed in 1959, proposed a new policy that represented a shift away from the so called Norwegianization or forced assimilation policy. Building on these recommendations, the Ministry submitted a Report to the Storting in 1962-63 that formed the basis for the first comprehensive parliamentary debate regarding the fundamental principles governing Norwegian Sámi policy. Likewise, it was in 1959 that the federal Admission Act, making Hawai'i a state, specified that a share of revenue from the

state's "public land trust," made up of 1.4 million acres of former Kingdom of Hawai'i crown and government lands, should be used for the betterment of native Hawaiians.

Assimilation or deculturation?

Minde exemplifies how the mindset of Norwegianization lingered on even after new policies were put in place and points to the socio-psychological consequences of forced assimilation and its influence on the Sami people over time (Minde, 2005). Much research has been conducted to increase awareness of how the kind of disempowerment minorities experience under assimilation has socio-psychological consequences, he writes. On the one hand, mechanisms of self protection to adjust to the social pressure are activated. On the other hand, under strong and persistent pressure, self respect and self worth can be undermined which in worst case can lead to self hate and exaggerated critical perception of other piers[13]. In an article by Peter T. Manicas, Professor of Sociology at University of Hawai`i at Manoa, he challenges the concept of assimilation, writing it best describes the process by which emigrants become socialized by the dominant culture; becoming accepted without notice by the dominant society. The indigenous of Hawaii were rather deculturised, he suggests. De-Hawaiianisation is the word used by Blaisdell. In this light, the Native Hawaiians, and possibly the Sami, are considered active agents in the process by which the colonized culture was transformed.

5.1.4. Post War policy developments in Norway

Nordic cooperation among Sami was initiated in 1953, and in 1956 it was decided to establish the Nordic Sami Council. The Sami Rights Commission was formed in 1980 and has been an active proponent of indigenous political and social rights (www.minorityrights.org). The Nordic Sami political program, adopted in Tromsø in 1980, sets out certain principles: Sami are one people and should not be divided by national boundaries; they have their own history, traditions, culture and language, and an inherited right to territories, water and economic activities; they have a right to self-development; and they will safeguard their territories, natural resources and national heritage for future generations.

And in 1987, with the passing of the Sami Act by the Norwegian government, a Sami Parliament was established. Elections were held and the Sámediggi opened on October 9th

[13] Ibid. Minde.

1989. The Sámediggi is an elected representative assembly for the Sámi in Norway, with representatives chosen by direct elections in 13 constituencies across the country. These elections are based on a separate Sami electoral register. The Sámediggi regulates its business within the frameworks laid down by the Sámi Act. A plenary session of the Sámediggi lays down the assembly's order of business and ground-rules, and regulates all other activity.

The Nordic Sami Council has been known as the Sami Council since 1992, when representatives of Russian Sami joined it. Through the Sami Council, Sami participate in the World Council of Indigenous Peoples, and, since 1989; the Sami Council has had consultative status with the Economic and Social Council of the United Nations.

The Sami Health Research report from 1999 provides one historic overview of how the Norwegian health care services were developed to better address the Sami population. The Sami health- and social worker unions were founded in the mid-1980s, with a shared goal to pay special attention to the needs of the Sami users and promote equal services for both the Sami and Norwegian population. Around this time the Norwegian Sami Council called for programs addressing special needs of the Sami in relationship to culture and language as well as health and social services. Several clinical institutions were established in Finnmark, improving the psychiatric and somatic cross cultural competence. The report also states that the Sami physician union put ethnic medicine and trans-cultural psychiatry on the curriculum and held seminars for health workers. In response to the history of suppression the Sami, Doctors Union put extra emphasis on cultural competence and seeing the Sami in light of their own history. (www.nsdm.no/eksterne_rapporter)

In 1995, the Norwegian government's Ministry of Health and Social Affairs came out with the "Plan for health and social services for the Sami population" in Norway (NOU 1995:6). This review included a description of the problem areas in regard to how the Norwegian public health services meet the Sami patients. The problems were often seen to be connected to lack of specific cultural knowledge among health care workers and a need for more knowledge; research, recruitment and competence building in this area. It also emphasised the need for a satisfactory interpreter service. Three recommendations were given; 1) assessment of research programs on Sami customs and traditional knowledge, 2) assessment of approaches to how information of this kind could be distributed to the health and public assistance arenas where this knowledge would be useful, and 3) assessments of collecting

information on experiences on the cooperation between health workers and traditional healers (NOU 1995:6). The Center for Sami Studies later did an evaluation and worked to build up a Sami medical competence center in conjunction with the University of Tromsø, and the Center for Sami Health Research (Report from Samisk Helseforskning, 1999). This is presently in function.

In 2000, the Storting established a Sámi people's fund. This fund is intended to be used for various measures to strengthen Sámi language and culture, and to serve as collective compensation for the earlier damage inflicted upon and injustice committed against the Sámi people by the forced assimilation policy. The fund is administered by the Sámediggi (St. mld. no 55). The Norwegian government's stated objective is to create a framework within which the Sámi people of Norway can maintain and develop their language, culture and lifestyle. This is rooted in Article 110 a of the Norwegian Constitution and the provisions of the Sámi Act. Norway is also treaty bound to protect the rights of the Sámi people through its ratification of various international agreements, in particular Article 27 of the UN Covenant on Civil and Political Rights and ILO Convention No. 169 on indigenous and tribal peoples in independent states. As an indigenous people and an ethnic minority in four different states, the Sámi population is in need of, and is entitled to, special status in relation to international and national law. Norway, with its current government, acknowledges that it has a special responsibility to ensure the development of Sámi language, culture and social structures (st.mld. no 55).

5.1.5. Post War policies in relationship to Native Hawaiian.

In 1974, the US Congress included Native Hawaiians in their legislature for Native American/ Alaskan Native (federalgrantswire.com). This was after years of insistence from Native Hawaiian leaders and communities focused on bringing attention to the issues of poor health and socio-economic status for their population (Akau, 1998). The Office of Hawaiian Affaires (OHA) is a semi-autonomous entity of the state of Hawaii charged with the administration of 1.8 million acres (7,300 km²) of royal land held in trust for the benefit of native Hawaiians. The OHA is governed by an elected board of trustees as outlined in the Hawaii constitution. OHA works to ensure the perpetuation of the culture, the enhancement of lifestyle and the protection of entitlements of Native Hawaiians, while enabling the building

of a strong and healthy Hawaiian people and nation, to be recognized both nationally as well as internationally.

In December 1985, The Native Hawaiian Health Research Consortium under ALU LIKE, released the *Native Hawaiian Health Needs Study – E Ola Mau.* This report identified the importance of culture and traditional healing practices for addressing health issues and improving health and wellness in the Native Hawaiian community and served as a spring board for much needed policy initiatives, one of which was Papa Ola Lokahi (POL), the Native Hawaiian Health Board. Papa Ola Lokahi was founded in 1987, as the US Congress was debating the passage of the *Native Hawaiian Health Care improvement Act*, which was to become a stepping stone in health care legislature for Native Hawaiians health concerns. (Papa Ola Lokahi (POL), Strategic plan, 2007).

The Native Hawaiian Health Care Improvement Act recognized the role of Native Hawaiian traditional healing practices and defined *Traditional Native Hawaiian Healer* as a practitioner:

(A) who-(i) is of Hawaiian ancestry, and (ii) has the knowledge, skills, and experience in direct personal health care of individuals, and

(B) whose knowledge, skills and experience are based on a demonstrated learning of Native Hawaiian healing practices acquired by- (i) direct practical association with Native Hawaiian elders, and (ii) oral traditions transmitted from generation to generation.

The Act went on to state: "*Nothing in this Act shall be construed to restrict the authority of the State of Hawaii to license health practitioners (42 USC 11708)".*

Then, in 1992: the Native Hawaiian Health Care Improvement Act was reauthorized incorporating the above definition, also including the statement enabling licensure by the State of Hawaii. 6 years later it was introduced into the State Legislature, recognizing the importance of traditional healing practices and definitions noted in the federal Native Hawaiian Health Care Improvement Act. Papa Ola Lōkahi was mandated to develop a process that would protect traditional Hawaiian healing practices and Native Hawaiians who practice them.

On October 31, 1998: the *Kahuna Statement* was developed for the legislature. In this statement the Elders expressed how they see themselves as instruments of the healing process, a tradition the state legislature is not knowledgeable of and therefore:

…" WHILE WE ARE GRATEFUL THAT THE LEGISLATURE HAS PASSED S.B. 1946, THE BLOOD QUANTUM, LICENSURE, AND CERTIFICATION ISSUES RAISED IN THE LEGISLATION ARE INAPPROPRIATE AND CULTURALLY UNACCEPTABLE FOR GOVERNMENT TO ASCERTAIN.
THESE ARE THE KULEANA OF THE HAWAIIAN COMMUNITY ITSELF THROUGH KUPUNA WHO ARE PERPETUATING THESE PRACTICES."

(From the Papa Ola Lokahi Chronology)

The Kahuna Statement was introduced into the State Legislature in 2001. The recognition of this statement initiated a process by which Native Hawaiian practitioners would be permanently exempt from licensure with the Native Hawaiian communities themselves serving as the appropriate reviewing authority. What this legislation did was to set in motion a process to exempt "qualified" Native Hawaiians practitioners from licensure in the State of Hawai'i. The legislation enabled Papa Ola Lokahi to form a panel or panels of traditional Native Hawaiian healers to address issues and recommend legislation relating to the permanent implementation of the purposes of this act. It also added composition requirements of the panel(s) convened by Papa Ola Lokahi, as well as it exempted practitioners from liability under medical licensing law. This was passed as Act 304 that same year.

In September 2002 Papa Ola Lokahi participated with the *Waimānalo Health Center* in hosting of a Healers Conference. One major concern was discussing Act 304 in depth. How this was done will be show under section 5.2.5.

Then at the end of 2002, Papa Ola Lokahi refined its recognition process in accordance with Act 304 for an organization and/or an agency wishing to provide traditional Hawaiian healing practices to their clients. The process requires that the requesting organization/agency submit a letter of request along with documenting evidence for recognition of its panel to Papa Ola Lokahi. Upon review, they then recognize by letter the panel as being constituted in accordance with Act 304 if it is in fact in compliance with the act. HRS 453-2(C) is amended to read:

Nothing in this chapter shall prohibit healing practices by traditional Hawaiian healers engaged in traditional native Hawaiian healing practices, both as recognized and certified as such by any kupuna council convened by Papa Ola Lokahi. No person or organization involved with the selection of kupuna council members, the convening of a kupuna council, or the certification process of healers under this subsection shall be sued or held liable for any cause of action that may arise out of their participation in the selection, convening, or certification process. Nothing in this chapter shall limit, alter, or otherwise adversely affect any rights of practice of traditional Native Hawaiian healing pursuant to the Constitution of the State of Hawaii.

In 2006, the health insurer AlohaCare accepted the criteria for credentialing under state law (Act 153), and began to provide for reimbursement for traditional Hawaiian healing services. Another Traditional Healers Conference was hosted by *Ho'ola Lāhui Hawai'i* (NHHCS) on Kauai. More than 50 traditional practitioners participated. This time the recommendations from the Conference addressed the need for the Native Hawaiian community to exert and protect its intellectual property rights as they relate to traditional healing practices; recognised an on-going need for *'aha* (conferences) focusing on traditional healing practices. Lastly, the NHHCS's was encouraged to take on the responsibility of developing "kauhale" (my translation: housing with multiple purposes) systems for Native Hawaiian practitioners. In addition, the concept of a strategic plan for implementation was supported.

5.2. Current Culturally Sensitive Health Care policies in practise

In this section the focus is primarily on what has actually taken place in regards to research, policy implementation and action.

5.2.1. In Norway addressing the Sami.

The overall life expectancy in Norway has increased since the 1970's and the health status of the Norwegian population is rated among the best in the world (Johnsen, 2006). In contrast to what is known about health among non-Sami in Norway, there is little health statistics on Sami population. The administrative director of Helse Nord RFH made a statement, on this year's Sami National day, that the health status of the Sami is equivalent to the Norwegian population in the same area (www.helse-nord.no). Though the Sami general health status seems to be better than that of the Native Hawaiians the statement made by the director

contrasts with a report made by the center for Sámi Health Research at University of Tromsø. Five years ago the university did a survey called SAMINOR, to examine ethnic differences in discrimination and living conditions among indigenous Sámi and majority Norwegian adults, living in northern Norway.

SAMINOR was the first large scale survey of health and living condition designed for investigating the Sámi population in particular. During 2003-2004 the survey was carried out among selected municipalities in Finnmark, Troms, Nordland and Trøndelag, Norway. The results showed that the Sami population reported a higher prevalence of experiences of ethnic discrimination as opposed to ethnic Norwegian, 62.5% as opposed to 12% ($p < 0.001$). The Sami-mix group reported 37.2%. The socio-economic conditions were inversely related to ethnic discrimination for the ethnic Norwegian. However, this was surprisingly not the case for the ethnic Sami. The conclusion draw from this was that the Sami population living in Norway often experience ethnic discrimination, comparing with the ethnic Norwegian. That ethnic discrimination has effects on both health and living conditions is documented in much international research. The SAMINOR study underlined the importance of focusing on ethnic discrimination and health status in future studies on the Sami population.

Patient choice is a complex issue that is frequently the subject of political debates. In practice, choice in the Norwegian health care system is determined by the fact that the NIS is public and monopolistic, to a large degree in public ownership and provides a service. Opting out of public arrangements involves considerable out-of-pocket payments. It is difficult to measure the degree of choice in the health care system, but the government has set up some mechanisms in order to increase that level of choice. The GP acts as gatekeeper and agent for the patient with regard to the provision of health services. At present 99% of the population is registered on the regular GP scheme, a list system, which aims to strengthen the patient–physician relationship by giving the patient the right to choose a regular general practitioner. This factor in with how traditional healing can be incorporated.

The organizational structure of the Norwegian health care system is, as before mentioned, built on the principle of equal access to services: all inhabitants, Sami as well, should have the same opportunities to access health services, regardless of social or economic status and geographic location. Each municipality has to decide how best to serve its population with primary care. Much of the spending in the municipalities is directed towards nursing, somatic

health care and mental health care. Regular general practitioners (GPs) are in practice self-employed, but financed by the NIS, the municipalities and by the patient's out-of-pocket payments. The regional level provides the basis for specialist health care. The regional health authorities plan the development and organization of specialist health care according to the needs of the regional population and services are provided by the regional health authorities' health enterprises. Their planning responsibility also includes health services supplied by other providers, such as private agencies. Tertiary-level specialized health care is delivered in accordance with regulations set out by central government[14]. To fulfil its aim, the organizational structure has three levels that mirror political tiers: the national/state level, the five health regions and the municipalities. The Northern Norway Regional Health Authority (Helse-Nord) has 462 000 inhabitants and the highest density of Sami population. This is where most of the Sami policy efforts are targeted. The Eastern Norway Regional Health Authority (Helse-Øst) has 1 671 000 inhabitants. A substantial amount of Sami people live here, in or within proximity to the Capitol. In between these two regions are the three others; The Middle, Western and Southern Norway Regional Health Authorities. It is within this structure culturally sensitive approaches are considered and have to be implemented.

In terms of the three plans for action as laid out in the Norway Public Review from 1996 (NOU 1995:6), the results are dispersed and not easily discovered. To assess a research program on Sami customs and traditional knowledge has been done. Assessing how to distribute this information on traditional knowledge to the health care service arenas where it could be of use has also been done to some extent but documentation of how it has been done or what the outcome is remains unclear. Concerning the third action, to consider gathering experiences about cooperation between health personnel and traditional healers, there is mention of experiments with the use of traditional healers at the Regional Hospital of Tromsø. It has not been possible to find any documentation on this either. One health researcher in the field, who wishes to remain anonymous, says that there is no evidence of such cooperation.

The means granted from the Ministry of Health and Social Affairs for the purpose of improving indigenous health care has been distributed by the Sami parliament towards educational and developing projects within the social health sector. It has been targeted at adapting the services to meet Sami user needs, training of health services personnel in Sami

[14] Ibid. Johnsen.

language and cultural understanding as well as interpretation services. The Sami Parliament has angled this use more towards development projects.

Sami Parliament management was in 2002 under evaluation by the Ministry of Health and Social Affairs but was expected to continue and so it is. In the Sami Parliament Council Statement, in 2002, on their health and social policies, it states that the project goal is, with the funding means, to integrate the Sami perspective in to health and social welfare arenas and in this way acknowledge the importance of Sami cultural understanding in social work. The statement addresses the children and adolescents; by strengthening the identity and connection to the Sami society among the youth, the council believes the Sami culture will secure its future. The council also addresses issues of Sami women's health and the health, wellbeing and respectful care for the Sami elders as well as the need for competence building regarding rehabilitation adjusted to Sami needs and reality.

In November, 2002, The Sami Parliament met with the Specialist Health Care Services, both within the somatic and psychosomatic field. From this meeting it was agreed that there is a need for, as well as professionally favourable with, a coordinated Sami competence centre. Such a centre would also be tied to the centre for Sami health research. A suicide epidemic among young Sami in the inner region of Finnmark in the early 1990's had given speed to the goverment funding process for a national competence center in Sami psychiatry. This became SANKS, the Sami National Competence Center - psychiatric care. SANKS has a national responsibility to contribute to the development of an equal mental health service to the Sami population. They are located in the middle of Finnmark and have regional psychiatric functions as well as national competence function for the whole Sami population. Sami from all over the country may be referred to them if they like. Beside the clinical services they are obliged to promote and do research and development projects, offer teaching and supervision, and offer special education and internships. SANKS is established as a part of Helse Finnmark HF and receive targeted government funding for its functioning.

There are few surveys performed on the Sami population but Sexton and Sørlie carried out a study related to the use of traditional and complementary treatments between Sámi and Norwegian psychiatric patient groups. The study showed that Sámi users attached greater importance to religion and spirituality and were less satisfied with the public psychiatric services than Sámi users who had not used traditional or complementary treatments. These

researchers concluded that including different aspects of traditional healing within the health services to the Sámi community should be given higher priority (Sexton and Sørlie, 2007).

One of the challenges in developing a more equal Health Care system sensitive to Sami needs or appropriate to their cultural expression, it the way the Health Care system is organised for the whole population. It is a challenge to the Storting and its various departments to accommodate a greater degree of Sami influence on their health concerns (St.meld nr.55). The implementation of Samidiggi increased the demand for communication flow between the departments involved. The Samediggi's desire for clarification of the division of responsibility is not easily resolved. The government response is referring back to the principle of sector responsibility. It is up to each specialist department to evaluate the need for coordination. It is recognised that the legal obligation to follow up in the Samidiggi as an independent political organ puts new demands on the traditional specialist department roles as administers of politics.

5.2.2. In Hawaii for Native Hawaiians.

From newspaper articles and the media the impression is that Hawaii seems to be struggling on the health coverage front. Of all ethnic groups living in Hawaii today, Native Hawaiians constitute the group with the highest proportion of risk factors leading to illness, disability, and premature death. Statistics reveal a high risk profile for Native Hawaiians, with the bulk of them having one of the following risk factors: sedentary life, obesity, hypertension, smoking, and acute drinking. The data depicts Native Hawaiians are experiencing high rates of circulatory diseases and malignant neoplasms, particularly digestive and respiratory types, which appear to be strongly associated to risk factors such as smoking, alcohol consumption, obesity, sedentary life, to mention some (Johnsen et.Al, 1996) Data also indicate that large segments of the Native Hawaiian population were recipients of state and federal sponsored health care services. This could be an indication of poverty since low income often is found to be a barrier to full access to health care systems. One must note that a few minority populations mirror this data. What is not in the data collected is information on Hawaiian health as compared to other Hawaiians (Office of the Hawaiian Affairs, 2009)

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving

access to health care services for people who are uninsured, isolated or medically vulnerable. They, too, see the Native Hawaiians facing cultural, financial, social, and geographic barriers that prevent them from utilizing existing health services. In addition, health services are often unavailable in the community (www.bphc.hrsa.gov/about/specialpopulations). Papa Ola Lokahi has been an important organization working to improve the health status and wellbeing of Native Hawaiians as well as others. They do this by advocating for, initiating and maintaining culturally appropriate strategic actions "aimed at improving the physical, mental and spiritual health of Native Hawaiians and their families and empowering them to determine their own destinies". (POL, Strategic plan, 2007).

Papa Ola Lokahi supports the efforts of *küpuna*, the masters or elders with expertise, to practice traditional Hawaiian healing and to promote the understanding and traditions of these practices. They advocate for the preservation and perpetuation of these (healing) activities to ensure that the rights and cultural integrity of traditional Hawaiian healing practices are respected and appropriately protected. Through presentations, demonstrations, workshops and working closely with the elders, POL seek to improve awareness of and sensitivity to Hawaiian cultural processes and the philosophies of spiritual healing, thus assuring their incorporation within the larger health and wellness arena. On their website the organization stresses that "Appropriate protocols compel respect for Native Hawaiian traditional healing practices and the wisdom of our küpuna".

The primary concern for Papa Ola Lokahi as they got stated in 1988 was to establish an appropriate Health Care structure for addressing Native Hawaiian health issues and concerns. This is The Native Hawaiian Health Care Systems (NHHCS). This program, consisting of five individual, community-based, independent functioning units funded within the health center appropriation, is designed to improve the health status of Native Hawaiians by making health education, health promotion, and disease prevention services available through the support of NHHCS. They use a combination of outreach, referral, and linkage mechanisms to provide or arrange services. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. In 2007, NHHCS provided medical care and enabling encounters to more than 7,022 people, they inform. The five units are based on five of the Hawaiian Islands, each with a special focus on Native Hawaiian health concerns. (NHHCS, http://www.nativehawaiian.net)

The Native Hawaiian Health Care Program also supports a health professions scholarship program for Native Hawaiians and administrative costs for Papa Ola Lokahi, the organization that coordinates and assists health care programs targeted at Native Hawaiians. The Native Hawaiian Health Career and Education Program (Kekukuilamalamaho`ola is Ho`ola's) has many goals. It is intended to increase Native Hawaiian Student performance at Hawaiian Immersion Schools, encourage student awareness of healthcare through career development education focusing on middle school and high school levels, create awareness of health care education opportunities at each grade level, recruit students into health profession training before the completion of high school, link students into health profession training before the completion of high school as well as to do scholarship assistance.

It also provides a limited number of scholarships. The program also provides College preparation and resources and provides family and parent activities in vocational training. The program vision is to empower and nurture Native Hawaiian children, families and community in attaining and increasing wellness through education and culturally-appropriate services and practices. The program Mission is to increase Native Hawaiian student's academic competency and to promote their pursuit of education in Healthcare related fields with a commitment to serve Kauai, Laka informed me, proud to share than many do come back to their community.

5.2.3. Designing Health Center to be culturally competent

The Waimanalo Health Center (WHC) organize their services from the perception that Native Hawaiians have unique cultural characteristics, values and traditions that affect healthy behavior choices, seeking of health care by western medicine providers, combined usage of western and herbal medicines, and distrust of non-community agencies. The WHC, writes about it self that it is uniquely capable of meeting the health care needs of the Native Hawaiian and Pacific Islander target populations in a manner that is culturally sensitive and community-based. This is contributed to the majority of staff and providers being either of the community or ethnicity of target populations. There are dedicated personnel for enabling services as well as staff training for all personnel in enabling care to reduce barriers to access and utilization. Primary care services provided include adult and family practice medicine, prenatal, family planning and women's health, as well as pediatric and adolescent health, for both episodic and wellness care for all patients.

The Waimanalo Health Center is an independent, community-based, non-profit entity. The WHC is governed by a member Board of Directors where the majority is from Waimanalo. Since 1992, the WHC has been a federally funded Community Health Center, one of ten Community Health Centers in the state that provides primary health care services to medically underserved populations. In their work they are linked with both public and private agencies, organizations, and individuals who serve in the community. Most importantly, it is pointed to that the other Community Health Centers in the state now collaborate on nearly all levels of operation, as a loosely defined ISD network facilitated by the Hawaii State Primary Care Association.

In searching for an example from Norway, Drag in Tysfjord presented project plans for a Sami Health Care Center in 2003. After years of processing and meeting resistance from the community council, it came into existence in 2008, as a Sami competent health service incorporated into the ordinary local Community Health Services. (Johnsen & Lind, 2003)

5.2.4. A Sami health professional:

Randi Nymo is a Sámi woman from Northern Norway. In presenting herself, she emphasizes that her local Sámi region is an upland peasant district within a specific landscape, yet also a region subject to assimilation policy and considered culturally marginal. She is a registered nurse, specialized in intensive and psychiatric care. In addition she is an approved supervisor in nurse service, has education in public administration and multi-cultural understanding and a Master degree in Health Science. Her clinical praxis is from the North Sámi area of Norway, both as leader and nurse in different fields. Currently she is an assistant professor in nurse education at Narvik University College. She sais about her work: “The main objective of my research is to develop a deeper understanding of how Sámi patients in marginal Sámi areas compose their total system of caring based on elements of traditional systems and public systems.”

In my informal telephone conversation with Randi Nymo she confirmed much of the findings saying: “Most other Indigenous people are more regulated than the Sami when it comes to the use of traditional healing practises. Many tend to think that the Sami have more (regulations) but this is not how it is. The Sami are used to keeping their knowledge well hidden but it does exist, not as an alternative to but complimenting the present health care system. Health Care

workers might be aware but not understand or chose to close their eyes to the traditional healers and the healers themselves do not speak up about their practises."

Nymo considers it to be a "keeping quite-process" or suppression going on in the Norwegian health care system. The Sami as a people, after the strong assimilation policies, are used to being suppressed and tend to take on a submissive role as patients. If they were to speak up or complain it could cause to challenge the dominant treatment system and evoke a resistance rather than improve the care they seek to get. Nymo considers this to be partly due to a fear of stigmatisation. The fear of stigmatisation is a strong conditioner for keeping traditional practises quietly alive amongst themselves, she said and suggested I read her article *Sensibility: a new focus in Sami health care education*. Here she addresses how colonialism has had significant bodily impact on Indigenous people through medicine. Sami have been burdened by mainstream prejugdism (poor genetic material) and inferior culture and language. The subsequent humiliation has impact on Sami when coming into contact with the Health Care system as patients. "Ethnic identity is connected to taboos, not only for patients, but also for Sami and non-Sami treaters." (Phillips et al, 2007). In spite of the intense assimilation many Sami understand illness as something caused of powers in nature or influences from other people. This can result in what Nymo calls "bodily Chaos". Not understanding the meanings or signs shown by patients may bring health care workers to interpret expressions of culture as signs of disease. Sami can be diagnosed as suffering from delusion. Sometimes they are visited by traditional healers in faith to "restore bodily cosmos". More, patients that try to conceal their Sami origin may be considered dishonest and be subjects to unequal treatment, per example resulting in untimely discharge.

5.2.5. Conferences; How they pave the way

Norway seminar:
In November of 1998 the *seminar on Sami folk medicine in Norway today* was convened by Institute for Sociology and Center for Sami Studies, in Tromsø. It was the first time in Northern Norway that researchers on folk medicine met with the practitioners of folk medicine, discussing theirs practises on an equal footing. A report was written and published:

From the seminar an increasing need among people to take part in the folk medical knowledge was verbalized, though it was expressed as accepted wisdom that not all people can practise

the traditional art of “reading”, which is one of the practises from old times. The concept of spiritual healing was discussed. According to Minde, the practitioners said that spiritual healing is a way of treatment that is inherited from their ancestors through formulas describing how to cure different illnesses. ”By reading these formulas the healer becomes a channel for some power beyond the human control” (Altern & Minde, 1998:99 – personal translation).

In this way one could heal illnesses through prayer, ailments such as rashes, pains, bleeding and itching and more. The practitioners do not consider it the most important *what* they can cure but rather that their methods supplement each other, Minde notes. There were stories told of doctors in the communities making use of both bio medicine and folk medicine. The healers honour the doctor’s knowledge by always asking the person if they have consulted one. Even if they have grown up only with folk medicine, the healers will make use of both traditions without perceiving them as conflicting. But there was an awareness that healing processes can be problematic in the sense that they can cause a worsening of the symptoms before the healing is complete. This requires trust in the process. According to Minde, the practitioners believe most serious healers have experience in handling such reactions.

The seminar facilitated a dialog between the presenters and the practitioners and stories were shared that expressed the cultural beliefs and customs. Knowledge about how healers are chosen through a social selection process was shared as well. Minde writes that it was of concern to the practitioners to rid their tradition of the mystification that presently surrounds it. The healers expressed a desire to voice their perspectives; how they can be considered mediums for the spiritual dimension and carriers of a knowledge that has been established with the nature people from long time ago.

The discussion also brought up the issue of documentation and how science has not yet developed the methods by which it can adequately document such a different knowledge system. This was seen as a concern in terms of developing a trust in research in the field of traditional knowledge and healing. At the end of the seminar the participants expresses a desire for more venues of the kind; a dialog between researchers, healer and users had been created, something all involved found constructive and important to follow up on.

In her introduction to the report from the seminar, social anthropologist, Ingrid Altern, emphasizes the importance of contextualizing knowledge. The conference is addressing the tension between two different belief systems; the biomedical and the traditional perceptions. These contrasting beliefs, tied to perception of the self, connectedness and cultural beliefs can cause dilemmas worth paying attention to, Altern expresses, especially when the dilemmas go "through" the person. This applies to the indigenous professionals with modern education who carry knowledge from the traditional healing practices as well[15]. Actually, the indigenous nurses having grown up with first had experiences of Sami healing can be perceived as the shamans of today, my anonymous informant has commented. They are the bridge builders between the medical worldviews and the reality of the Sami patient.

Hawaii Conference, 2002:

In September of 2002 at The Waimanalo Health Center (WHC) on O'ahu held its Biennial Conference. The conference was built on the momentum of WHC's first conference 2 years earlier, which had provided an international community forum to explore, discuss and seek wisdom on recognizing and preserving indigenous healers and their healing practices. Acknowledging the role of compassion in sustaining the medicinal healing arts throughout the generations and its infinite ability to be inclusive and embrace things that are similar as well as things that are different, was clearly stated in the conference invitation.

The Conference was sponsored by Waimanalo Health Center, Papa Ola Lōkāhi and Hawai'i State Primary Care Association. The purpose of the conference was to actively involve traditional Native Hawaiian healers and Native Hawaiian healthcare organizations in the evolution of traditional Native Hawaiian healing. Present were representatives from primary care entities such as the Community Health Centers, and the NHHCS's, articulating how traditional healers and their healing practices are blended with allopathic care in these settings to afford Native Hawaiian patients a comprehensive, culturally competent array of health care services. Discussions were begun at pre-conference meetings to distil central issues facing practitioners and providers of traditional medicine. The conference then provided the forum for extended discussions and formulation of actions on the key issues and recommendations.

It is worth noticing that cultural rules of conduct and behavior were incorporated in the conducting of the conference in order to protect, and in respect of, the traditional healers' gift,

[15] Ibid. Altern & Minde

expertise and lineage. This approach to gathering people with different perceptions on healing practises seems to facilitate cultural sensitivity and promote understanding of self and others.

Two major recommendations from the conference were made to Papa Ola Lokahi (POL). Firstly, to promote more discussion on each of the islands through ‘aha; and secondly, to be accountable for legislation regarding Act 304. POL contracted Kumu Kawaikapu Hewett to conduct consultation sessions with kūpuna statewide on issues surrounding Act 304. Kūpuna on all islands were interviewed. Then in December that year, POL refined its recognition process in accordance with Act 304 for an organization and/or an agency wishing to provide traditional Hawaiian healing practices to their clients. The process requires that the requesting organization/agency submit a letter of request along with documenting evidence for recognition of its panel to POL. POL, upon review, then recognizes by letter the panel as being constituted in accordance with Act 304 if it is in fact in compliance with the act. The following year three of the NHHCS’s petitioned for recognition of its Kupuna Councils in compliance with the Act and this was granted by POL.

5.2.6. A Native Hawaiian traditional healer

Frank Kawaikapuokalani Hewett is a kumu hula (hula teacher) and a well known composer. Founder and Director since 1978 of *Kuhai Halau O Kawaikapuokalani Pa Olapa Kahiko*, he was also the Director of Alternative Medicine at the Waimanalo Health Clinic for 10 years. His teachers include his grandmother, Iwa Kanae, Aunty Emma DeFries, recognized as her protégé, and Edith Kanaka'ole whom he studied with while attending the University of Hawaii at Hilo. His work in the field of Hawaiian culture takes him off island and abroad on a regular basis. Hewett shares much of his family's background and values in his teaching.

This following information is from a video recording of NBC Hawaii News8, done in November 1998.It is a television program on how Native Hawaiian and doctors work to integrate ancient and modern practises and how hands on healing and heart research has become partners. As a hula student of Frank Kawaikapuokalani Hewett at that time, I briefly visited Waimanalo Health Center. Since this television interview is relevant and available to me, I chose to use it as an example of the discourse on cooperation between traditional healing and western medicine in Hawaii 11 years ago. This is a short summary:

As a Traditional healer and Director of Alternative Medicine at Waimanalo Health Center, Hewett explains that traditional healing is about wholeness and connection. "Healing starts with *Ha* - the breath", he goes on and explains how he focuses his mind in prayer to 'Io, the supreme god, combining their forces to let the energy flow through his hands and into the patient. The program also interviews a cardiologist and a medical doctor on their experiences with and knowledge of healing. Using a more scientific vocabulary their concepts and ideas about health and wellness processes expressed support for healing touch, whether from a traditional healer, a caring person or nature's beauty. To this Frank Hewett says: "You can't measure it, you can't understand it, it just works and if it does, let's be happy and move on". Today's medicine must combine ancient and modern practises, he emphasises: "Doctors are healers, too, we cannot discard that. They are good healers. And we must work together, not separately, to encourage the success and achievement of healing for all people."

Meeting him again briefly this summer 11 years later, he still holds the same belief that the different traditions of native healing and modern medicine can work together - with respect, honouring each others traditions. But he also commented that he had left the field "because of the entanglement." This I interpret to mean that the legal issues are complex and opinions are many in the institutional efforts. Therefore at this time, Hewett has chosen to put his capacities into back into teaching the traditions of his lineage through music, hula and healing arts.

6. Discussion

According to Fay, signs of resistance are vital elements in the shaping of cultures and societies (Fay, 2007). There are many factors that contribute to the variations in policy approaches in implementing indigenous rights in these two States. While I have tried to focus on the most critical, much more research required. It is clear, however, that both the Sami and the Native Hawaiians have gone through a similar period of forced assimilation or deculturation that seems to have left traces of psychological trauma in the cultural identities; devaluation of self and psychosomatic symptoms – which have affect the Sami in particular – as well as physical health issues, which seem to have impacted the Native Hawaiian more so that the Sami. It appears that both the Sami and the Native Hawaiians as peoples, initially had a "low conflict" response to the colonizing forces, and it has taken special situation to bring

conflicts to the surface and cause the resistance necessary to create social and systemic change and ultimately a say in how health care is provided for its people.

6.1. Indigenous movement and preservation of healing traditions

In this attempt to look at what happens when modern health care policies encounter traditional healing practises and concepts, several elements stand out. Historically we can see a pattern of Western dominance over indigenous healing practices and traditional concepts of health being suppressed. Statistically we can see evidence of inequity in health outcome for the indigenous as a group. This has become a call for action and multiple ways of dealing with the culturally conflicting ideas and the discourse on traditional healing practises meeting western medicine has emerged. Blaisdell, physician, researcher and Kanaka Maoli (Native Hawaiian) social activist, says that for the Kanaka Maoli they have either to hide with the risk of extinction, submit to dominance with the risk of exploitation, or, stand up for conservation of their traditions and gain control over their land and resources (Blaisdell, 1991). Is this also the choices that face other indigenous people like the Sami? According to Gaski, Sami policy has never been directed toward the establishment of a separate Sami nation state. It has been more geared towards establishing rights that will assure the survival and growth of the Sami and their culture in their own ancestral areas of settlement. The Sami political awakening was, first and foremost, culturally based, according to Gaski, and directed at getting language and cultural rights. It was later that land and water rights became an issue. The preservation of Sami traditional healing does not seem to have been given as much attention as in Hawaii. Since health and wellbeing is closely linked to culture, and modes of healing are expressions of these, I am curious why there is such an obvious difference in focus, Norway and Hawaii.

The Helse Nord RHF task document 2007 confirms that the starting point for equal health services to the Sami population in the national health strategy for 2007-2010 is with Sami language and culture. It states that the democratic rights to equal services for the Sami population involve that the health services must develop knowledge of Sami language and culture to better communicate and offer good services (Helse-Nord RHF, oppdragsdokument, 2007). The Regional Health Concerns have established a line of communication with the Sami parliament to discuss issues of common interest concerning the Specialist health care services to the Sami population but it seems like it is still a very long and bureaucratic way to go for the Sami to gain more influence. This confirms to me how complex the issues are

concerning indigenous rights, paths of power and the incorporation of traditional knowledge and practices into the current health system.

Access to education for indigenous people is of great importance. Similarly as we have seen in Hawaii, the establishment of Sami institutions of learning was from early on promoted as a means to secure Sami self-awareness and identity[16]. It was important that the Sami themselves be involved in their resources utilized in academic research. "The need for Sami researchers became extremely important as a political consideration, both as a disciplinary concern and as a matter of cultural policy" Harald Eidheim writes in his article on Sami Self Hood[17]. Research, education and communication are all important factors that not only serve to shape and promote identity but also promote health in a modern society. To gain control in these areas is for the Sami and Native Hawaiians, therefore, are very important political arenas linking into health policies in numerous ways.

How to further facilitate cooperation or integration of practices?

In regards to the traditional healing practises being maintained and incorporated into the dominant health care system, Hilgenkamp and Pescaia (2003) believe we can improve our ways by being respectful and open to learning from each other. This is close to, but not the same as the voice of former director of Alternative Medicine at Waimanalo, Hewett, who believes cooperation is possible with respect, though a respect that does not confuse the different traditions, but honours each. In Norway, Sexton and Sørlie (2007) write about an "integration of both perspectives" as the remedy, and, that one should consider including different aspect of traditional healing for Sami patients in Norwegian hospital settings. They also bring in the concept of complementary medicine as an alternative choice for culturally appropriate treatment. Hetta (1986) suggest increasing knowledge and awareness of differences and as health professionals to take on a more "sympathetic view" to other cultural backgrounds with their own traditions, values and beliefs.

In her article, Nymo points to how good relations are not only for the feeling of well-being for the patients but also assuring medical safety. "The education programmes for health personnel has to emphasise inter-human conditions as a way to be safe in treatment and care" (Phillips et al, 2007). Practising cultural safety in nursing should therefore also allow some traditional

[16] Ibid. Gaski.
[17] Ibid. Gaski.

treatment to be used in mainstream health care settings, she writes. This could prevent some patients leaving the hospital to only rely on the care of their own, and in this way missing out on the potential benefits available through western medicine. In culturally safe health care settings, health care personnel will not feel threatened by traditional treatment which in turn can enable Western Medicine to develop into a more inclusive discipline by accepting its own limitations and by accepting the possibilities of other health and well-being knowledge[18].

As we can see, there are many suggestions on how to approach a successful meeting of these two traditions. They address a shift in attitude; a movement away from scepticism towards openness. Then the next step is to integrate or to cooperate. These are two different actions. Looking up *integration* in the Hawaiian dictionary I do not find the word (Pukui, 1986). Cooperation is *ho'olaulima* or *kokua* which also mean to help or work together. It was also said about the Sami healers that they considered their healing as complimentary to, and not instead of, medical expertise. Incorporation, then, becomes a joining of forces. A certain space has to be created for this to take place and this need to be included into health care planning.

6.2. National and International policy processes go together.

In looking more closely at how the governments of Norway and Hawaii have dealt with incorporating traditional healing practises, it is important to explore how national attempts to incorporate the international Conventions or Declarations in their politics have faired. National and state policies need to be in compliance with international law and accepted covenants relating to human rights and indigenous peoples' rights relating to health and wellbeing (Josefson, 2007). Tensions can be noticed in international organisations' attempts to develop norms and standards regarding indigenous people globally through United Nation (UN), the World Bank (WB) and the International Labour Organisation (ILO). There are dilemmas concerning these categories and conditions, as well as their goals (Kymlicka, 2007). These tensions seem to be reflected in how Norway and the US have chosen different routes or international policy instruments to back up their national policy processes.

Though non-signers of the Convention no 169, the US Government and the Government of Hawaii have taken concrete measures to meet the needs of the indigenous people. Even

[18] Ibid. Phillips, et al.

though the native Hawaiians see their cause as different from the one of other indigenous people, like the American Indians and Alaska Natives, it seems like the political organization of these groups have paved the way in Congress for the Native Hawaiians to be heard. Also, on a federal level, the Native Hawaiians seem to have been given a greater degree of self determination on how to provide culturally sensitive and culturally accepted health care through their Native Hawaiian Health Board, Papa Ola Lokahi. Whereas the Sami have been granted a Sami Parliament, their influence on health care policy for themselves is still under the control of the Ministry of Health and Social Affairs under the Storting. This is, as I understand, due to the national policy and organisational structure. Ideally this should not stand in the way for communication, cooperation and institutional efforts but more explicit adjustments might be required to bring indigenous rights into the current national policies.

Reading article 25 of Convention no 169, which Norway was the first country to ratify 20 years ago, the Government shall ensure that adequate health services are made available to the Sami peoples, or shall *provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health*. As well health services shall, to the extent possible, be community-based. *These services shall be planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines*. The health care system shall give preference to the training and employment of local community health workers, and focus on primary health care while maintaining strong links with other levels of health care services. Lastly, the provision of such health services shall be co-ordinated with other social, economic and cultural measures in the country (ILO Convention no 169).

The NOU 1995:6, that underlies most political action in relation to the Sami, reads in relationship to considering gathering experiences about cooperation between health personnel and traditional healers:

"In this consideration/review it has been mentioned that traditional healers, through their knowledge and authority, can have an important role in explaining and motivating some patients to follow the doctor's instructions, in addition to helping the patient feel safe at the hospital. The committee is of the opinion that experiences with collaboration between Sami

healers and health practitioners ought to be gathered. We know that a few primary care services have harvested positive experience with the doctor giving a first opinion, while the traditional healer gives a kind of a second opinion and then possibly explains to the patient the use of the prescribed medication."

(NOU 1995:6, personal translation)

This proposition could be seen as positive, since it does address cooperation, acknowledge traditional healers as having knowledge and authority, and because it is the only one of its kind that I have found so far. But as my informant in Sami research field pointed out, the wording does not express recognition of the traditional healer as an equal partner representing an adequate system of its own. When we look to the efforts of Papa Ola Lokahi in clarifying and then addressing the interests of the Native Hawaiian community, there are obvious differences. In Norway, modernization has come so fare that the hegemony of bio medicine seems to stand undisputed (Altern & Minde, 1998). Public health care has been accessible to everyone, including the ones without resources, so that the practitioners of folk medicine have not given the Health care system any competition.

This is to some degree changing now as the Sami have gotten their own independent political organ in the Samediggi and, have it in their interest to keep the Norwegian government on their toes in regards to their international obligations concerning participation in developing health care services. That the Sami health care so far has been adjusted to the national health, service of Norway should still not be and excuse toleave out a crucial part of the everyday experience of a minority's well-being as Siv Kvernmo presents it (Gaski, 1997). For more successful treatment results, language skills, comprehension of cultural taboos, and traditional practises have been put on the Norwegian health care agenda due to the Sami people. The negotiation of health concepts and its culture has begun a new phase in Sami health care.

Indigenous efforts

The Hawaiian story tells about a continuous drive to counteract the forces that have been creating the structures, beliefs and behaviours so destructive to them. Throughout their history, they have struggled to find ways to maintain the health of the Hawaiian community against all odds. These institutional efforts can be seen in the latter half of the 20th century with such organizations as Alu Like, the E Ola Mau studies, the Native Hawaiian Health Care Improvement Act which established Papa Ola Lokahi (Native Hawaiian Health Board). Also

the creation of the reauthorization in 1992 which established the Native Hawaiian Health Care Systems and the Native Hawaiian Health Scholarship Program.

To the social activist, Blaisdell, asserting control of their own land and ocean resources are essential for Native Hawaiian livelihood and "survival as the first people in our homeland with a distinctive culture in which spiritual affiliation and sharing are paramount rather than individualism, exploitation, materialism, waste and destruction of our natural environment" (Blaisdell, 1991). The push for Native Hawaiian self determination and the attempts by Hawaiians to perpetuate their culture and revive their language and values is by some believed to include the need for Hawaiians to improve their wellness by returning to what Hawaiians once knew and lived. This is not unproblematic, however. The Hawaiian experience is what makes them who they are and places them in the junction of past, present and between individuality and the collective of different communities (Eriksen, 2002). No culture and no tradition is static in this sense. The evolution of traditional healing clearly leads us to difficult questions that need frank and honest discussion and more important, practical and heart-felt solutions. It seems like Papa Ola Lokahi has put their efforts into going beyond the rhetoric and to establish functional environments and protocols that supports healers, healing practices, health care clinics and centers, as well as patients. Their successfulness might be attributed to their responsibility both as an NGO in the Hawaiian community and their mandated responsibilities as and GDO to implement public policies.

6.3. Dealing with Culturally Sensitive Health Care

What constitute cultural sensitivity and competence has been interpreted differently in Norway and Hawaii. In Norway, great attention has been given to language and how to provide proper interpretation services, though these efforts are mainly targeted at northern Norway and therefore not accessible to all Sami. This fact, as well as some programmes to educate health personnel in Sami culture and customs, has been the main ways of implementing cultural sensitivity. Although cultural competence can help decrease the communication barriers between patients and clinicians, it cannot, in isolation, address systematic issues that are rooted in unequal access and resource allocation that reproduce barriers to care (Wong, 2008). Gradually, we can also see institutional efforts to facilitate Sami influence in planning and administration through per example creating cooperative organs for communication between departments. In Hawaii, it seems like the Native Hawaiians were involved in the planning and development of their health care system from an

early stage. Language is given less attention, though still important. Hawaiian words are incorporated in both the official and daily language, which adds a dimension to English as the main language of communication. Maybe this is so because of the greater need to communicate in a multicultural environment.

When we look at Norway and Hawaii, evidence indicates that the health plan with the greatest degree of what Dr. Wong calls cultural humility, is in Hawaii. One can only speculate why this is so, however, it seems that political activism among Native Hawaiians has not been matched by political activism among Sami. Perhaps one factor accounting for this is the different histories of Native Hawaiian and the Sami in relation to domination by others. Until 1893, the Hawaiian population was master over its own territory and has a longer history of sovereignty. The Sami were nomads while borders were being defined and redefined. It has been brought to my attention there are theories or assumptions on how Island vs. nomad mentality play into conflict resolution strategies. Rather than to expand on this, I will point to how the Native Hawaiians are a fairly homogenous group in a very multicultural society, though westernized still made up of many immigrants. While the Sami are a rather inhomogeneous group in a much more homogenous society of a Norwegian majority.

It also seems like Native Hawaiians have more clout in influencing political change than Sami. One factor for this could be they have more wealth that the Sami. Native Hawaiians have capital in the ceded lands administered by OHA. According to an informal calculation done by Henry Minde, the level of Norwegian government yearly funding (less than 1 % of GNP) to Sami politics roughly equivalents the same level of funding as in 1870. (Minde, 2005). The yearly revenues from Hawaiian ceded lands in additional to federal funds might very well empower the Native Hawaiians politics. A more accurate evaluation of the indigenous economy of Norway and Hawaii are beyond the scope of this study.

The political climate of Norway and US society is also different. US Government is assertively funding indigenous programs, such as Native Hawaiian Health Board that support traditional healing practices, as a way of making amends of past indiscretions inflicted on indigenous people of the US by Government. The Storting give funding to Samediggi too, but as mentioned, this is a relatively small amount of money and, as far as the results of this investigation, little of this goes towards health programs as such, though some is used on

Sami research which can be seen as to indirectly benefit the Sami by the dominant health care system becoming more educated and thereby possibly adjust future funding priorities..

One can recognize the political and social attitude of US as more religious based than Norway, too. This, in general, fosters a broader acceptance of spiritual based healing. Norway has a state religion but separates the two. In Norway, the medical community has a stronger political influence promoting its evidence based medical practices and upholding an expert position. The shortcomings of this stance is in the many evidence based studies showing that positive attitude fostered buy spiritual healing practices are beneficial in building a stronger immune system in patience. People in general are gaining more understanding of how health and wellbeing are best promoted through physical and emotional treatments. To this, that one can just have evidence based approach to healing, is short sighted.

To indigenous people, Kinship-systems and sense of belonging to place(s) are important safety networks in multiple ways. Today possibilities are changed; neither Sámi nor Native Hawaiians can live independent of the dominant welfare systems. Folk Medicine is still in use, though. Sadly, Bio medicine lacks theories and concepts that place folk medical practices in an equal position. Still medical health care professionals have to some degree been able to cooperate with traditional healers, more so in Hawaii than in Norway. As shared by both Nymo and my Sami informant, most of the Sami practices are still hidden. But today, individuals can dare to display their Sáminess through narratives of Sámi culture language and history, Nymo says. This, she believes, has a decolonizing potential.

For some time the Sami folk medicine practises have seemed to be dying out, but over the last years there has been a revival. This seems to parallel the Native Hawaiian traditional medical history which, according to Blaisdell, since 1985 is re-awaking. The growing acceptances for alternative practices seem to create a space in which traditional practices also can become more visible and the Sami and Native Hawaiians have a forum in which to claim their cultural heritage back in public. The WHO strategy for implementation of Traditional Medicine (TM) is seen parallel to the implementation of Complementary/Alternative Medicine (CAM). (http://www.who.int/mediacentre/news/releases/release38/en/). Complementary and Alternative Medicine (CAM) is in Norwegian legislation but not referred to as “medicine”, but as “alternative treatment” (Besl. O. nr. 104, 2002-2003). Practitioners are called alternative “treater”, and without explicit reference to the concept, “complementary

practitioners". Today traditional healers belong to this category as well. CAM customers are seen essentially as consumers, rather than as patients entitled to patients' rights. Patients' rights only apply for established health services as defined in the law, which means that they apply in practice when health personnel are engaged in CAM treatment within, as well as outside the public health services.

Protection of intellectual property

Though indigenous traditional knowledge has been an issue for international attention for many years, it is still vulnerable to misappropriation. Modern scientific knowledge has been able to draw biomedical use of folk medical knowledge for commercial use. Capitalist powers rather than spiritual powers set the premises for development against the indigenous will and interests. The Permanent Forum for Indigenous Issues emphasise that indigenous traditional knowledge is not simply an intellectual property issue. Likewise, it is not simply a human rights issue, a trade issue or an amalgamation of those issues. The proper protection of indigenous traditional knowledge is an indigenous issue and indigenous peoples should be central to the process" (http://www.un.org/esa/socdev/unpfii/en/about_us.html).

7. Concluding reflections

In the process of attempting to gain political power, the Sami and Native Hawaiian have had to express themselves in a way that can be understood by those that are in power. They have had to use the language of the majority for this purpose. There is a potential danger in this, Gaski prophesizes; "when we have learned the language of power, we may begin to forget the thought patterns that form the foundation of our own language" (Gaski, 1997: 20). He sees it as a paradox that it seems to be those that were successful in the assimilationistic schools who have the most successful careers. And how do they relate to their heritage, Gaski questions. Do they refer back to their cultural background or rather to their "newly acquired ethno-political position vis-à-vis the minority and the majority societies" as their main reference?

In carrying out this research, I was acutely aware of this aspect of the investigation; how, as an outsider to both the culture of native Hawaiians and the Sami, could I write sensibly about indigenous issues? I experienced myself tapping into the dilemmas that indigenous people face when they want to be heard and respected in a society where power rests with others. How are they to make themselves understood by a society where power rests with those

having not only a different language but also different culture and norms? The question facing me in this research role is an old one. To paraphrase the words of a well known and respected researcher of Sami culture, "we fool ourselves if we think the methods and analytical tools we use will let us rise above who we are as persons and our presence in the field" (Nergård, 1994).

In this paper, three areas of concern for developing health care services with a culturally humble health care plan incorporating indigenous rights stand out. Firstly, the demand for traditional Sami and Native Hawaiian healing practices has been articulated and is both on the international and national agenda. We have seen different approaches to meet this demand that have been developed. Secondly, there is a concern to articulate what constitutes quality and safe Sami and Native Hawaiian healing practices. This is answered indirectly by discussing the challenges in interpretation of health beliefs and indicating the shortcomings relying only on scientific evidence. Also, while in Norway this is still unclear, the Hawaii example show how this can be handled by giving legal power to the natives and traditional healers themselves. And this flows into the third concern: by giving much attention to what has taken place politically, legally and culturally to make traditional medical services available in a professional setting, it is my hope that some light is shed on what areas needs further research for future cultural, political and legal evolution of culturally humble health care planning.

In Hawaii, in spite of the achievement in creating a Native Hawaiian Health Care system, there seems to be greater health disparities for the native Hawaiians than is obvious among their Sami brothers. The challenges in overcoming social inequality are many and the major threats against public health in developed countries like unemployment, social inequity, poverty and racism need to be addressed from many directions and on multiple levels. Still, the consistent perpetuation of indigenous cultural heritage in conjunction with modern education gives hope for a better future. "Health plans, by the very nature of their roles in facilitating the healing interaction between clinician and patient, can stand to either impede progress or catalyze actions that lead to the elimination of health disparities[19]." From what this investigation has shown, I share the opinion of Dr. Wong, that cultural sensitivity is not sufficient in health care plans and policy-making. More integration in this area is need. I will appeal for the concept for cultural humility. By recognizing and admitting that the present

[19] Ibid, Wong.

dominant Health Care system in Norway, though given superiority by law, still has much more work to be done to achieve health and wellbeing while integrating cultural humility. I do not mean this to be interpreted to always be accepting of differences. This could cause numbness and loss of self respect for both parties. Rather, cultural humility can mean for policy makers to keep developing a willingness to *engage* in diversity (Fay, 1996) with a sense of modesty, without feeling threatened by it.

With that recognition, the health plans of both Norway and Hawaii are encouraged to assume leading roles in demonstrating a commitment to overcome racism and social injustice affecting the health care of its indigenous population alongside all citizens. How this can best be achieved would deserve further investigation.

Literature

Akau, Mahealani and William Akutagawa, Kim Birnie, Mei-Ling Chang, Everett Kinney, Dr.Sita Nissanka, David Peters, Rebecca Sagum, Dexter Soares, Hardy Spoehr (1998). *Ke Ala Pono: the Native Hawai'ian community's effort to heal itself*. Pacific Health Dialog. Vol.5.No 2.

Altern, Inger & Gunn Tove Minde. (2000). Samisk Folkemedisin i dagens Norge: Sami Folkmedicine in Norway today. Volume 9. Tromsø: Skriftserie, Senter for samiske studier.

Blaisdell, Kekuni, M.D. (1991). *Historical and Philosophical Aspects of Lapa'au Traditional Kanaka Maoli Healing Practices* Presented August 24, 1991 in Pu'uhonua in Hawaiian Culture. Sponsored by Kahua Na'auao, and supported by a grant from the Hawai'i Committee for the Humanities.

Dallmann, Winfried K. *The Saami of Norway*, edited and compiled from various sources (Elina Helander, Nordic Saami Institute 1992; Wencke Brenna, Ministry of Local Government and Labour's Section for Saami Issues 1997); amendments and updates by the editor) (retrieved, 1.8.09)

Johnson, David B. Ph.D., Oyama, Neil. MPH, MBA, Le Marchand, Loic M.D., Ph.D. (March, 1996). Papa Ola Lokahi Hawaiian health update: Mortality, morbidity, morbidity outcomes, and behavioural risks. Hawaii MEDTEP Research Centre.

Eidheim, Harald. (1997). *Sami Selfhood*. Article in Gaski, Harald, 1997. Sami Culture in a New Era. The Norwegian Sami Experience. Davvi Girji, Karaskjok, No.

Engesæter, Olaug. Digitalskolen, Historisk institutt © Universitetet i Bergen (retrieved 25.08.09).

Esping Andersen, G. (1990). *The three worlds of welfare capitalism*, Cambridge: Polity Press.

Gaski, Harald. (1997). *Sami Culture in a New Era*. The Norwegian Sami Experience. Davvi Girji, Karaskjok, No.

Greipsland, Torbjørn. (2004). Aloha fra glemte nordmenn på Hawaii. Emigrantforlaget. Norway

Halvorsen, Knut. (2008) *Å forske på samfunnet*: en innføring i samfunnsvitenskapelig metode. Cappelen Akademiske Forlag, Oslo.

Helse-Nord RHF (2007). Oppdragsdokument by Sylvia Brustad for Ministry of Health and Social Affairs.

Helman, Cecil. (2007). *Culture, Health and Illness*. 5th ed. Hodder Education, Uk.

Hetta, Ole M. (1986). *Hvorfor Våre Behandlingsmodeller Virker Eller Ikke Virker - Psykiatri på Tvers av Kulturgrensene.* Nordic Journal of Psychiatry, Volume 40, Issue 1, pages 25 - 32 Hetta, Ole M.: personal contact pr. telephone 17.2.09.

Hilgenkamp, Katheryn and Pescaia, Colleen. (2003). *Traditional Hawaiian Healing and Western Influence*. Californian Journal of Health Promotion, vol.1 special edition: Hawaii. P.34-39. (electronically retrieved 10.2.09)

Johnsen J.R. (2006). *Health Systems in Transition: Norway.* Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Josefson, Eva. (2007). *Samene og de nasjonale Parlamentene* - kanaler for politisk innflytelse. Galdu Cala: Tidsskrift for urfolksrettigheter Nr. 2/2007.

Kerns, Carolyn J, Meehan, Nancy K, Carr, Rebecca L, Park, Lauretta I. (2003). *Using cross-cultural definitions of health care*. Nurse Practitioner. *Diversity*. Oxford University Press.

Kennet, Patricia ed. (2004). *Handbook of Comparative Social Policy*. Edward Elgar Publishing, UK.

Kvernmo, Siv. (1997). *Developing Sami Health Services - A medical and Cultural Challenge*, article in: Gaski, Harald. (1997). Sami Culture in a New Era. The Norwegian Sami Experience. Davvi Girji, Karaskjok, Norway.

Kymlicka, Will. (2007). *Multicultural Odysseys – Navigating the New International Politics of Diversity.* Oxford University Press.

Morley, Peter and Wallis, Roy (Ed). (1978). *Culture and Curing.* Anthropological Perspectives on Traditional Medical Beliefs and Practises. University of Pittsburgh Press.

Minde, Henry (2005). *Fornorskning av samene - hvorfor, hvordan og hvilke følger?* Galdu Cala - tidsskrift for urfolks rettigheter no3/2005.

Mrantz, Maxine & Mark (1974). *Hawaiian Monarchy*. The romantic years. Aloha Publishing.

Nergård, Jens-Ivar. (1994). *Det skulte Nord-Norge*. Ad Notam Gyldendal.

Nergård, Jens-Ivar. (2006). *Den levende erfaring*. En studie i samisk kunnskaps tradisjon. Oslo: Cappelen akademiske forlag.

NOU 1995: 6 Plan for helse- og sosialtjenester til den samiske befolkningen i Norge.

Nymo, Randi. (2007). Sensibility: a new focus in Sami health care education, Article in: Phillips, Sandra et al, 2007. (Re)*Contesting Indigenous Knowledges & Indigenous Studies.* The Australian Journal of Indigenous Education vol.36S-2007. The University of Queensland, Au. Randi Nymo: personal contact pr. telephone 11.8.09.

Ouye-Nakama, Gwen N. MPH. (2004) *Policy Brief - A Historical Overview of Hawaii's Prepaid Health Care Act.* No 04-01, July. HIPA (Hawaii Institute for Public Affairs)

Papa Ola Lōkahi – POL. (1997). Strategic Plan.

Pollan, Brita, (1993). Samiske sjamaner: religion og helbredelse: Gyldendal.

Pukui, Mary Kawena and Samuel H. Elbert. (1986). *Hawaiian Dictionary*. Revised and enlarged edition. University of Hawaii Press.

Sexton, Randall M.D. and Tore Sørlie. (2008). *The Use of Traditional Healing among Sami Psychiatric Patients in the North of Norway*. International Journal of Circumpolar Health 67:1 2008 (Electronically retrieved, 10.2.09)

Sørlie, Tore, and Jens-Ivar Nergård. (2005). Treatment Satisfaction and recovery in Saami and Norwegian Patients Following Psychiatric Hospital Treatment: A Comparative Study. Transcult Psychiatry 42(2):295-316.

St.meld. nr. 28 (2007-2008) Samepolitikken.

St.meld nr. 55 (2000-2001) Samepolitikken

Besl. O. nr. 104, (2002-2003) Alternative behandling

Tabrah, Frank L. (2007). Health Care Hawaii Style. Model for the Nation?

United Nations. (2007). The Forum on Indigenous Issues (UNPFII) of the United Nations. Report of the Secretariat on Indigenous Traditional Knowledge.

Wong, Winston F. (2008). *Confronting the Uncomfortable: Health Plans and Health Disparities: A Moral Dilemma in a Morally Driven Industry*. The Permanente Journal/ Winter 2008/ Volume 12 No. 1.

Electronic Resources

Aira, Harriet. (Published 14.02.2008). Vil bedre helsetilbudet. [Retrieved (01.10.2009)]. http://www3.nrk.no/kanal/nrk_sami_radio/1.4811648

Johnsen, Elin & Linstad, Line. (2003). Nye helse- og sosialtjenester for den samiske befolkning. [Retrieved (01.06.09)]. http://www.telemed.no

Office of Hawaiian Affairs. [Retrieved 2009]. http://www.oha.org.

NHHCS, [Retireved 2009]. http://www.nativehawaiianhealth.net/history.cfm

Papa Ola Lōkahi. [Retrieved 2009]. www.papaolalokahi.org

Papa Ola Lōkahi, March 2008. Chronology of Events. [Retrieved 17.2.2009]. http://papaolalokahi.org/coconut/news/pdf/POL_chronology.pdf

Senter for Samisk Helseforskning. University of Tromsø [Retrieved 10.05.2009]. http://uit.no/medsamisk/2011/

Traditional medicine. 2003. World Health Organization. [Retrieved 15.03.2009; 10.04.2009]. http://www.who.int/mediacentre/factsheets/fs134/en/

United Nations. Permanent Forum for Indigenous Issues. [Retrieved 11.07.2009]. (http://www.un.org/esa/socdev/unpfii/en/about_us.html).

WHO: Traditional Medicine Strategy 2002-2005. 2002. World Health Organization. [Retrieved 12.01, 2009], http://www.who.int/medicines/publications/traditional/policy/en/

WHO: Strategy for implementation of Traditional medicine (TM). [Retrieved 10.03.2009]. http://www.who.int/mediacentre/news/releases/release38/en/

Other Internet Resources:

US Census Hawaii: http://www.census.gov/pubinfo/www/NEWnativehawML1.html

Office of Minority Health: http://www.cdc.gov/omhd/

Office of Hawaiian Affairs: http://www.oha.org/

Native Hawaiian Health Board: http://www.papaolalokahi.org/

Hawaii State Department of Health: http://hawaii.gov/health

Hawaii Primary Care association: http://www.hawaiipca.net/

Prepaid health care: http://hawaii.gov/labor/dcd/aboutphc.shtml

Norway Parliament: http://www.stortinget.no

Sami Parlament: http://www.samediggi.no/artikkel.aspx?AId=83&MId1=3&back=1

Center for Sami studies: http://www.sami.uit.no/

Sami cooperation organ: http://www.helse-nord.no/arsmelding2007/samisk.htm

Ministry of Health and Social Affairs: http://www.regjeringen.no/en/dep/hod.html?id=421

SANKS: http://www.helse-finnmark.no/category10180.html

SSB: http://www.ssb.no/samer/

NAKMI:

http://www.nakmi.no/nyheter/artikkel.asp?SeksjonID=2&NyhetID=189&SpraakID=1

Pedersen, Steinar, *Finnmarksloven og 1800-tallets norske nasjonalisme.* [Retrieved 25.08.2009] http://www.galdu.org/web/index.php?artihkkal=129&giella1=nor

Dagens Medisin: [Retrieved 25.09.2009] http://www.dagensmedisin.no/nyheter/2008/10/31/fremdeles-uten-likeverdig-/index.xml