

# Māori Health REVIEW™

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Issue 93– 2021

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## Tēnā koutou katoa

Nau mai, haere mai ki a Māori Health Review. We aim to bring you top Māori and Indigenous health research from Aotearoa and internationally. Ngā mihi nui ki Manatu Hauora Māori for sponsoring this review, which comes to you every two months. Ko te manu e kai i te miro nōna te ngahere, Ko te manu kai i te mātauranga, nōna te ao.

## Welcome to the 93<sup>rd</sup> issue of Māori Health Review.

In this issue, we feature two articles on COVID-19 public health strategies, and how they may impact on Māori. We also include outcomes from a national hui on heart health equity. The hui represented foundational work for Manawataki Fatu Fatu for ACCESS, a 3-year programme of translational research into equity in heart health outcomes for Māori and Pacific peoples. Finally, we present scoping reviews showing that further research is needed to provide effective support services for Māori with autism and Māori with speech-language disorders.

We hope you find this issue informative and of value in your daily practice. We welcome your comments and feedback.

Nga mihi

**Dr Matire Harwood**

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## Expansion of a national COVID-19 alert level system to improve population health and uphold the values of Indigenous peoples

**Authors:** Kvalsvig A et al.

**Summary:** Public health researchers have proposed an expansion of the national COVID-19 alert level system. They note that several aspects of the current system have not worked adequately for Māori. The revised alert levels range from 0 through 6, with Levels 0-1 representing prepare (green), Levels 2-4 representing stop the spread (amber) and Levels 5-6 representing stay-at-home (red). Benefits of the revised system include: upholding Te Tiriti and implementing a more equitable response, better calibrating controls to the level of risk, responding to new knowledge, signalling improvements and innovation, supporting harmonisation with Australia (and the wider world), and establishing protective measures for a safer future.

**Comment:** An interesting view presented here, and great to see Māori and Te Tiriti perspectives being highlighted.

**Reference:** *Lancet Reg Health West Pac.* 2021;12:100206.

[Abstract](#)

## COVID-19 vaccine hesitancy and acceptance in a cohort of diverse New Zealanders

**Authors:** Prickett KC et al.

**Summary:** In a web-based survey of 1824 New Zealanders conducted before the COVID-19 vaccine rollout, 70% of respondents indicated they would likely take the vaccine once available. Survey respondents were part of a large, diverse, pre-existing social research sampling frame. Respondents who were unsure about or unlikely to get the vaccine were more likely to be young, female, and less educated, and were primarily concerned about unknown future side effects. There was no statistical association between ethnicity and vaccine hesitancy. The researchers suggested that public health efforts aimed at increasing vaccine acceptance among Māori and Pacific peoples should focus on inequities in health care access to increase uptake.

**Comment:** As I write this (mid-September), vaccination rates for Māori lag behind those of all other ethnicities. However, in this same week, Māori providers have taken charge of the vaccination programme to make it work for them. As a result, we've seen 10,000 Māori receive the vaccine each day. As Tina Ngata tweeted, in the same way we've prioritised Groups 1 (border workers), and 2 (aged >65 years) based on their increased risk of contracting COVID-19 and experiencing its complications, we must do the same for Māori.

**Reference:** *Lancet Reg Health West Pac.* 2021;14:100241.

[Abstract](#)

## Reported sources of health inequities in indigenous peoples with chronic kidney disease

**Authors:** Huria T et al.

**Summary:** A Kaupapa Māori meta-synthesis has evaluated the epidemiology of chronic kidney disease (CKD) in indigenous peoples. Quantitative studies involving Māori, Aboriginal and Torres Strait Islander, Métis, First Nations Peoples of Canada, First Nations Peoples of the United States of America, Native Hawaiian and Indigenous Peoples of Taiwan were screened, and 180 studies published up to 31 December 2019 were included. The David R Williams framework was used to categorise findings. Biological processes, particularly type 2 diabetes and cardiovascular disease, were frequently reported as the principal cause of health inequities in indigenous peoples with CKD. Social and basic causes of disparities, including racism, economic and political/legal structures and socioeconomic status, were infrequently reported or absent in the reviewed literature.

**Comment:** Although many of us would understand that upstream determinants, beyond the surface causes, contribute to health inequities including chronic kidney disease, it is disappointing to read that these are not well reported. I hope these findings encourage researchers to look beyond the surface – because only then can we develop appropriate interventions that eliminate inequities.

**Reference:** *BMC Public Health.* 2021;21(1):1447.

[Abstract](#)

## Equity of colonoscopy provision and quality in Māori and New Zealand Europeans

**Authors:** Donachie M et al.

**Summary:** Māori are significantly less likely to receive colonoscopy than NZ Europeans, according to a retrospective comparative study conducted at Whanganui Hospital. The study analysed 2962 colonoscopies (385 from Māori; 2577 from NZ Europeans) between September 2016 and March 2020. The rate of colonoscopy provision in participants aged ≥40 years was 6.1% among Māori versus 9.1% among NZ Europeans ( $p < 0.0001$ ). However, colonoscopy completion rates, colonoscope withdrawal times and polyp detection rates were similar between Māori and NZ Europeans. While the adenoma detection rate was significantly lower in Māori than NZ Europeans (32.7% vs 40.0%;  $p = 0.028$ ), this was not observed when participants were stratified by 10-year age cohorts. The authors concluded that improving equity requires the addition of colonoscopy provision rates, across ethnic groups, to other key performance indicators.

**Comment:** Great recommendations here to not only improve access to potentially life-saving investigation/treatment but to also ensure that equity (of care and its outcomes) for Māori is measured and reported.

**Reference:** *ANZ J Surg.* 2021;91(7-8):1575-1581.

[Abstract](#)

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Research Review publications are intended for New Zealand health professionals.

## Connecting people, well-being, and environment through waka ama in Aotearoa New Zealand

**Authors:** Severinsen C et al.

An interview-based study has highlighted the multifaceted benefits of participating in waka ama. As well as the health benefits for paddlers, waka ama also has a strong tikanga, encouraging use of te reo Māori through karakia, waiata, and terms associated with waka. Opportunities are created for participants to experience and connect with the natural environment. The researchers concluded that their study shows effective ways of improving health and well-being within communities with a particular focus on waiora, the spiritual connection between hauora and the environment.

**Comment:** I know Nga Kaihoe o Aotearoa's recent survey identified similar findings. Other benefits of waka ama include its smoke-free kaupapa, the provision of healthy kai/water at events and whānau ora across generations.

**Reference:** *Health Promot Pract.* 2021;22(4):524-530.

[Abstract](#)

## Health system barriers to accessing care for children with weight issues in New Zealand

**Authors:** Wild CE et al.

**Summary:** Lack of access remains a crucial barrier to improved health outcomes for children with obesity in New Zealand, according to an interview-based study. A total of 64 semi-structured interviews were conducted for 71 participants of a family-based multidisciplinary healthy lifestyle programme for children and adolescents. Half the interviews were with Māori families. Five health system factors affecting engagement were identified via thematic analysis: the national policy environment, funding constraints, lack of coordination between services, difficulty navigating the health system, and the cost of primary health care. The authors concluded that comprehensive approaches, accompanied by a clear implementation strategy and coordinated across sectors, are needed to improve engagement.

**Comment:** As a recent *British Medical Journal* article commented, childhood obesity, and children's exposure to obesogenic environments, may have been exacerbated by COVID-19 and its lockdowns (see [BMJ. 2021;374:n1716](#)). COVID-19 demonstrated that governments can act swiftly to enable interventions for the public good. Let's encourage a similar response for our tamariki.

**Reference:** *Health Serv Res Policy.* 2021:13558196211016011 [online ahead of print].

[Abstract](#)

### Independent commentary by Dr Matire Harwood



Dr Matire Harwood (Ngapuhi) has worked in Hauora Māori, primary health and rehabilitation settings as clinician and researcher since graduating from Auckland Medical School in 1994. She also holds positions on a number of boards, committees and advisory groups including the Health Research Council. Matire lives in Auckland with her whānau including partner Haunui and two young children Te Rangiora and Waimarie.

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## Heart health equity hui report

**Authors:** Manawataki Fatu Fatu for ACCESS

**Summary:** A national hui took place on July 8, 2021, bringing together participants working on heart health equity in New Zealand, and documenting research, evaluation and current service delivery models and programmes for Māori and Pacific peoples. The hui represented foundational work for Manawataki Fatu Fatu for ACCESS, a 3-year programme of translational research into equity in heart health outcomes for Māori and Pacific peoples. Identified strengths of the current landscape included a strong desire to achieve equity, the presence of vibrant Māori and Pacific communities, and the current restructuring of the health system. Barriers included insufficient staffing, resourcing and time, poor communication and relationships between health professionals, and with patients and whānau, a lack of cultural safety in organisations, low levels of system health literacy due to institutional limitations, gaps in data, research or knowledge, inconsistent implementation of proven interventions, and systemic factors influencing patients' access to health care. In a creative session, participants shared their ideal pictures of Māori and Pacific heart health outcomes. A common theme was the desire for greater prioritisation of upstream and community-based interventions, and more resources allocated to primary care. The hui culminated in 8 major areas for action over the next 6-12 months:

- Supporting Māori and Pacific people in the workforce
- Utilising and scaling resources
- Facilitating community building
- Launching a communication platform
- Establishing a discharge summaries project
- Sharing findings from whānau hui
- Commitment to Pūrākau
- Being guided by Te Tiriti o Waitangi.

**Comments:** As one of the team leading this hui in Manukau, it was a pleasure to work with so many wonderful people on ideas that will achieve equity in cardiovascular health for Māori and Pacific people. Sir Jerry Mateparae's inspiring opening, and the section on 'Creativity' may motivate others to think outside the box!

**Reference:** *University of Auckland, New Zealand, ISBN 978-0-473-58843-4.*  
[Abstract](#)

## Māori and autism

**Authors:** Tupou J et al.

**Summary:** There are broad differences in Māori and Western understandings of autism, according to a scoping review of published information. A total of 13 publications relating to autism and Māori, from peer-reviewed journals and grey literature, were reviewed. The prevalence of autism was shown to be slightly higher in Māori than non-Māori New Zealanders. Findings highlighted a need for diagnostic and support services that are both effective and culturally appropriate for Māori. The researchers discussed what these findings may mean for future research and the provision of services for Māori with autism.

**Comments:** Good to see research on this important kaupapa – Māori and autism. I hope it leads to further study. I'd be interested in knowing more about access to, and timing for, diagnosis and management for Māori.

**Reference:** *Autism. 2021;25(7):1844-1858.*  
[Abstract](#)

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## Māori speech-language therapy research in Aotearoa New Zealand

**Authors:** Meechan RJH & Brewer KM.

**Summary:** Māori speech-language therapy research undertaken in New Zealand in the past 20 years has been identified in a scoping review. Eligible literature included all original research published in peer-reviewed journals, and all honours, Masters and PhD theses. A total of 21 publications (12 articles, 9 theses) were included in the review. Most research was published in the last 10 years. A te reo Māori (Māori language) focus was evident in more than half of the theses but only 1 article. Kaupapa Māori research methodologies were used in 7 theses but only 3 articles. The authors noted that with such a small amount of research across the entire speech-language therapy field, there is no aspect that has been researched to a level sufficient to inform evidence-based practice for Māori.

**Comments:** I often hear about the lack of kaupapa Māori speech language therapy from Māori with stroke-related speech disorders, and their whānau. Perhaps something for the Māori Health Authority and Health New Zealand to take up? This paper certainly provides a good foundation for future work/service development.

**Reference:** *Speech Lang Hear. 2021 Jul.*  
[Abstract](#)

## How to measure racism in academic health centers

**Authors:** Adkins-Jackson PB et al.

**Summary:** US researchers have proposed a mixed-data formative assessment for measurement of institutional racism in academic health centres, with a view to enabling antiracist strategic planning and decision making over time. The assessment provides a composite score of racism on three levels – individual, intra-organisational and extra-organisational. It includes qualitative components at each level, for example randomised patient interviews, observations and evaluations of academic health centre operations from students and community health workers at the intra-organisational level, and local, regional and government policy analysis at the extra-organisational level. The researchers suggested that assessment be undertaken annually.

**Comments:** The authors present both quantitative and qualitative measures of racism in healthcare at three levels (individual, intra-organisational and systemic). Importantly, they demonstrate how the data can be used to inform antiracist policies and funding decisions that eliminate health inequity. I think we should consider something similar with the health reforms.

**Reference:** *AMA J Ethics. 2021 Feb 1;23(2):E140-145.*  
[Abstract](#)



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