

Māori Health REVIEW™

Making Education Easy

Issue 88 – 2020

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Abbreviations used in this issue

CVD = cardiovascular disease
HR = hazard ratio
OR = odds ratio

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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 88th issue of Māori Health Review.

In this issue we begin with a positive study that provides evidence in support of school-based sore-throat swabbing to detect Streptococcal A and reduce the incidence of acute rheumatic fever in Māori schoolchildren. We need more programmes like this to narrow the inequities in the health burden for Māori.

We hope you enjoy our selection for this issue and welcome your comments and feedback.

Nga mihi

Dr Matire Harwood

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School-based Streptococcal A sore-throat treatment programs and acute rheumatic fever amongst indigenous Māori

Authors: Walsh L, et al.

Summary: School-based sore-throat swabbing reduced the incidence of first-presentation acute rheumatic fever in a retrospective analysis of Māori schoolchildren in the Bay of Plenty. The incidence of first-presentation acute rheumatic fever was assessed after three interventions in three open cohorts of Māori schoolchildren from 2011 to 2018 and compared with incidences from 2000 to 2010 prior to any intervention. The annual incidence of first-presentation acute rheumatic fever declined by 60% from 148/100,000 to 59/100,000 in Māori schoolchildren in the Eastern Bay rural cohort (mean deprivation decile 9.80), who received school-based sore-throat swabbing with nurse and GP support ($p=0.002$). Similarly, the annual incidence of first-presentation acute rheumatic fever declined by 48% from 50/100,000 to 26/100,000 in Māori schoolchildren in the Western Bay (mean deprivation decile 5.98), who received GP care with school-based sore-throat swabbing in 3 high-risk schools ($p=0.044$). However, in Māori schoolchildren in Eastern Whakatane township and surrounds (mean deprivation decile 7.25), who received GP management only, the annual incidence of acute rheumatic fever doubled from 30/100,000 to 69/100,000 ($p=0.047$). Notably, school-based interventions narrowed gender disparities with significant reductions in the incidence of acute rheumatic fever in male Māori schoolchildren.

Comment: Great to have this paper in support of school-based programmes for Māori. I'm aware that some funders have concerns about the fiscal costs for school-based programmes. However, achieving equity may require additional or focused funding or support – one size doesn't fit all, as confirmed here.

Reference: *Pediatr Infect Dis J.* 2020;39(11):995-1001.

[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 Rangiura and Waimarie.



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Noho Haumaru: Reflecting on Māori approaches to staying safe during Covid-19 in Aotearoa

Authors: Pihama L, Lipsham M.

Summary: This article gives a historical overview of Māori experience of epidemics and pandemics since first contact with Pākehā in 1769. It discusses the failure of colonial governments to ensure the protection and wellbeing of Māori and reflects on cultural practices used by Iwi and Māori organisations to protect Māori communities during the COVID-19 crisis.

Reference: *J Indig Soc Dev.* 2020;9(3):92-101.

[Abstract](#)

Estimated inequities in COVID-19 infection fatality rates by ethnicity for Aotearoa New Zealand

Authors: Steyn N, et al.

Summary: The COVID-19 infection fatality rate for Māori was estimated to be 50% higher than that of non-Māori based on existing demographic and health data for ethnic groups in New Zealand and international data on COVID-19. The estimated inequity may be higher depending on the relative contributions of age and underlying health conditions included in the analysis. The authors commented that inequities 'will be exacerbated by racism within the health care system and other inequities not reflected in official data'.

Reference: *N Z Med J.* 2020;133(1521):28-39.

[Abstract](#)

Comment: Two important papers that present the context for Māori and COVID 19, and a description of the features of an Iwi-led and Kaupapa Māori response. As the authors suggest, such a response should be underpinned by Māori principles and values in addition to strategies that result in the eradication of social injustices.

Inequity in one-year mortality after first myocardial infarction in Māori and Pacific patients: how much is associated with differences in modifiable clinical risk factors?

Authors: Mazengarb J, et al.

Summary: Ethnicity accounted for a 3-fold variation in one-year mortality after first myocardial infarction according to results of a registry study. A total of 17,404 patients hospitalised with their first myocardial infarction between 2014 and 2017, and who underwent coronary angiography, were identified from the All New Zealand Acute Coronary Syndrome Quality Improvement (ANZACS-QI) registry. Patients' ethnicity was reported as European/other (76%), Māori (11.5%), Pacific (5.1%), Indian (4.3%), and Other Asian (2.9%). The hospital admission rate for first myocardial infarction before age 60 years was 29% for patients of European/other ethnicity and 55% for patients of Māori, Pacific and Indian ethnicity. Māori and Pacific patients were more likely to present with heart failure and advanced coronary disease. Māori patients had a significantly higher all-cause mortality at 1 year compared with European/other patients (HR 2.55; 95% CI 2.12–3.07).

Reference: *N Z Med J.* 2020;133(1521):40-54.

[Abstract](#)

Ethnic differences in cardiovascular risk profiles among 475,241 adults in primary care in Aotearoa, New Zealand

Authors: Selak V, et al.

Summary: Māori and Pacific people had a higher prevalence of CVD risk factors than other ethnic groups in a cross-sectional analysis of 475,241 people aged 35–74 years who had a CVD risk assessment in primary care between 2004 and 2016. Ethnicity was reported as European/other (55%), Māori (14%), Pacific (13%), Indian (8%), and Other Asian (10%). Prevalence of smoking, obesity, heart failure, atrial fibrillation and prior CVD was much higher in Māori and Pacific people compared with other ethnicities.

Reference: *N Z Med J.* 2020;133(1521):14-27.

[Abstract](#)

Comment: As some of you may have seen in the editorial and associated media, we had issues with the reviewers of the second paper (see our [editorial](#)). This was disappointing in many ways but perhaps mostly because there had been a call for current CVD risk data by ethnicity and here we were, being blocked as we tried to get this information out.

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MINISTRY OF HEALTH TO LAUNCH Whakamaua: Māori Health Action Plan 2020-2025

The Ministry of Health is set to launch Whakamaua: Māori Health Action Plan 2020-2025 on 30 July 2020.

Whakamaua will give effect to He Korowai Oranga: Māori Health Strategy by setting out a suite of outcomes, objectives, and priority areas for action that will contribute to the achievement of pae ora – healthy futures for Māori. As you will know, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori.

Whakamaua is underpinned by the Ministry of Health's new Te Tiriti o Waitangi framework – which provides a tool for the health and disability system to fulfil its stewardship obligations and special relationship between Māori and the Crown.

Whakamaua has been shaped by feedback provided through an extensive engagement process. *Whatua - Summary Report: Engagement for the development of Whakamaua 2020-2025* will be published as a companion document to Whakamaua – giving visibility to the voices of Māori communities and the health and disability sector.

More details can be found at
www.health.govt.nz/whakamaua





Hui: a partnership in practice in familial hypercholesterolemia

Authors: Benatar J, et al.

Summary: A Hui was held to empower a large whānau with a history of severe premature heart disease and familial hypercholesterolemia. As a result, a closed social media page with detailed information and a family tree was created to ensure present and future generations access appropriate screening and treatment. With the facilitation of health professionals, this has enabled the whānau to take ownership of their health and inform other health professionals about their disorder. The authors commented that 'A national systematic programme is also needed to manage this condition with important health outcomes that can be averted if treated from a young age.'

Comment: Love this research – practical, meaningful, and whānau-based. I can see this being used in other health areas including genetic or familial health conditions.

Reference: *N Z Med J.* 2020;133(1522):63-70.

[Abstract](#)

Ethnic disparities in vaccine safety attitudes and perceptions of family doctors/general practitioners

Authors: Lee CHJ, Sibley CG.

Summary: Ethnic differences in attitudes to vaccines and the influence of GPs in New Zealand were identified using data from the 2017 New Zealand Attitudes and Values Study survey (N=17,072). A positive perception of GPs and high vaccine safety agreement was reported by 59.4% of Māori compared with 74.7% of Europeans, 72.3% of Asians and 65.8% of Pacific people. Key correlates for higher vaccine safety agreement among Māori were increased GP satisfaction, health care access and being non-religious.

Reference: *Vaccine.* 2020;38(45):7024-7032.

[Abstract](#)

Investigating spatial variation and change (2006–2017) in childhood immunisation coverage in New Zealand

Authors: Marek L, et al.

Summary: Childhood immunisation coverage in New Zealand varied by socioeconomic and demographic factors in an analysis of 4,482,499 individual immunisation records obtained from the National Immunisation Register for 2005–2017. Immunisation rates decreased in the least deprived areas and increased in more deprived areas, but immunisation rates were lowest in the most deprived areas. Immunisation coverage was associated with spatial variation with the highest immunisation coverage in areas with a high ethnic European population.

Reference: *Soc Sci Med.* 2020;264:113292.

[Abstract](#)

Comment: These two papers make the same point in their conclusion – to use the findings to improve immunisation policy, services and rates. With a new vaccine for COVID-19 available in 2021, we really need research that will develop and, even better, demonstrate what works.

Suicide and 'hidden suicide': a comparison of rates in selected countries

Authors: Snowdon J.

Summary: Suicide rates of young Māori considerably exceeded those of young non-Māori in a review of rates of suicide and 'hidden suicide' in New Zealand, Australia, Ireland and Spain. Rates of suicide and 'hidden suicide' were calculated and compared using estimated population figures and online cause-of-death from 2014 to 2016. Rates of 'hidden suicide' were relatively low in all four countries. Suicide rates in New Zealand decreased in late life and peaks of youth suicide were attributed to high rates of Māori youth suicide.

Comment: Common causes for death in young Māori men include suicide and road traffic crashes. I've often wondered if the latter included 'hidden suicide'. We've done a lot to reduce death rates for the majority of health conditions in Aotearoa apart from two notable exceptions – diabetes and suicide. Do we need reminding that Māori rates for these are amongst the highest in the world?

Reference: *Australas Psychiatry.* 2020;28(4):378-382.

[Abstract](#)

Equity in access to zero-fees and low-cost primary health care in Aotearoa New Zealand

Authors: Jeffreys M, et al.

Summary: Results from repeated waves of the New Zealand Health Survey from 1996 to 2016 showed that the population accessing low-cost primary health care increased over the 20-year study period. Access to low-cost care was highest for Pacific people, but Māori and Asian people also accessed low-cost care more than people of European ethnicity. Access to low-cost care was strongly predicted by area-level deprivation in non-Māori, while Māori were more likely to access low-cost care at all levels of deprivation. The authors commented that 'future policies to improve access should be fully aligned with the articles of Te Tiriti o Waitangi and should focus on equity'.

Comment: Really important evidence here, demonstrating that current funding policies do not work for Māori when they attempt to access primary care. For too long we've focused on area-level deprivation (which is important, think your area code has more impact on health than genetic/DNA code) when clearly there are other 'barriers' to access that we must address.

Reference: *Health Policy.* 2020;124(11):1272-1279.

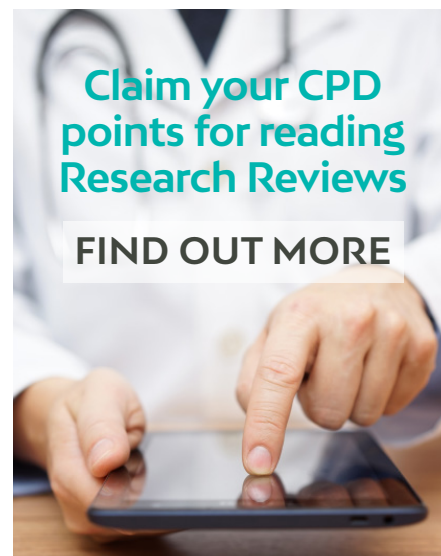
[Abstract](#)

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Ethnic disparities in access to publicly funded bariatric surgery in South Auckland, New Zealand

Authors: Rahiri JL, et al.

Summary: Māori were less likely to gain access to publicly funded bariatric surgery than New Zealand European or Other European patients in the Counties Manukau Health bariatric programme from 2011 to 2017. A total of 2519 patients were referred to the programme and 1051 patients received bariatric surgery. Of these 68% were Other European and 63% were New Zealand European compared with 42% Asian, 41% Māori and 28% Pacific ($p < 0.05$). Differences in socio-demographics, comorbidity or attrition did not explain the significantly lower likelihood of Māori receiving bariatric surgery (OR 0.53; 95% CI 0.42–0.68).

Comment: As a GP working in Counties, I've had a number of people return from the first step in the bariatric surgery pathway feeling despondent and judged. Jamie Lee has made some excellent recommendations here – I hope the clinical leaders take them on board. This research was undertaken as a part of Jamie Lee Rahiri's PhD – I look forward to her graduation and acceptance of the Dean's prize in December!

Reference: *Obes Surg.* 2020;30(9):3459-3465.

[Abstract](#)

Chronic conditions in the community: Preventative principles and emerging practices among Māori health services providers

Authors: Gifford H, et al.

Summary: The practices of three Māori health service providers in the prevention of chronic conditions in Māori were investigated in a three-phase research project using Kaupapa Māori methodology and an instrumental case study design. The research phases included interviews with seven participants in two small groups, individual interviews with 44 key informants and in-depth investigation of prevention practices in a prevention case study for each Māori health service provider. Each provider found it challenging to achieve well-being through health service delivery in the state-funded and contract-defined environment. The research identified high levels of acute need in the provider communities requiring increased resources and a broader health services response to prioritise prevention.

Comment: Good to see this information published. In my experience many of these changes have been driven by the providers themselves. Consolidating and presenting the evidence for better funding models, including Waitangi Tribunal claims in health, requires huge effort which is not only taxing for Māori services and their workforce but can stymie innovation.

Reference: *Health Promot J Austr.* 2020 Apr 18. doi: 10.1002/hpja.346.
Epub ahead of print.

[Abstract](#)

The physical health of Māori with bipolar disorder

Authors: Cunningham R, et al.

Summary: The physical health of Māori and non-Māori with a diagnosis of bipolar disorder was compared to investigate the relationship between severe mental illness and the physical health of Māori. Patients with a diagnosis of bipolar disorder in 2010 were identified from mental health services data. Follow-up over 5 years for non-psychiatric hospital admissions and deaths showed that Māori with bipolar disorder had a higher level of morbidity and a higher risk of death from natural causes compared to non-Māori with bipolar disorder. The lack of difference in hospitalisation rates between Māori and non-Māori indicated that under-treatment of physical health conditions may have contributed to the higher risk of death from natural causes in Māori.

Comment: This research group is reporting important results in the area of better wellbeing for people, and particularly Māori, living with mental illness. These people are often marginalised in society, as well as in health care and research. I will be keeping an eye out for future studies.

Reference: *Aust N Z J Psychiatry.* 2020;54(11):1107-1114.

[Abstract](#)



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