

# Pacific Health Review

Making Education Easy

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**Kia orana, Fakalofa lahi atu, Talofa lava, Malo e lelei, Bula vinaka, Taloha ni, Kia ora, Greetings.**

## Welcome to Pacific Health Review.

In this edition, we are pleased to report on the 2014 International Pacific Health Conference hosted by the Health Research Council (HRC) in Auckland in November. The fono was attended by around 250 delegates who gathered to hear speakers from countries including the US, Australia, New Zealand, Hawaii and the Federated States of Micronesia. It was a special opportunity to share insights and explore the challenges of how to use research to improve health outcomes for Pacific populations with colleagues working in many different contexts. In addition to some of the conference highlights covered in this edition of Pacific Health Review, a publication with expanded abstracts of all the presentations is available at <http://pacificconference.hrc.govt.nz/abstracts-and-papers/>.

Congratulations to Dr Nuhi Seve-Williams and the Pacific HRC Committee for hosting this successful meeting. Malo lava and faafetai to all the contributors to this edition. To our readers, thank you for your continuing support, your feedback is always welcome.

Best wishes

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## About the fono

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The theme of the conference – 'Pacific health solutions through research and practice' – provided an extraordinary opportunity for interdisciplinary dissemination of health research, practice and knowledge from New Zealand, Australia, the Pacific Islands, the United States and beyond. The speakers' call to action emphasised the need to address the health challenges of Pacific communities globally.

The conference focused on some of the key issues facing Pacific peoples at a global level, including the high incidence, prevalence and economic cost associated with non-communicable diseases such as obesity; cardiovascular disease and type 2 diabetes; the growing health inequities in the Pacific region; and the greater prevalence of mental health disorders, suicide attempts, tobacco and alcohol use among Pacific youth.

Professor Sir Mason Durie, KNZM, opened proceedings with a discussion about the principles for the advancement of Pasifika health in the 21<sup>st</sup> century. This was followed over the next three days by a programme with 90 speakers in seven streams. The speakers reflected the rich diversity of the Pacific and beyond, and were from New Zealand, Australia, the United States (including Hawai'i and Guam), Tonga, American Samoa, Papua New Guinea, the Federated States of Micronesia, Northern Mariana Islands, Bangladesh, South Korea, and Thailand.

Pacific health research helps to build the capacity and capability of Pacific peoples in research and contributes to the Pacific knowledge base. We see through conferences such as this that Pacific health research and practice at the global level is moving in new and strategic directions, which will ultimately help to improve the health and well-being of Pacific peoples globally. Communicating the HRC Pacific vision of 'optimal health for Pacific peoples' was an important part of the conference. In his keynote speech, Professor Sir Mason Durie shared three principles: engagement, enlightenment and empowerment. These three principles remain at the core of the work ahead in improving health outcomes for Pacific peoples at a global level.

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## Markers of Pacific health research in the 21<sup>st</sup> century

**Presenter:** Professor Sir Mason Durie

**Summary/Comment (Leitu Sa):** Sir Mason Durie, a highly regarded leader and expert in Māori health, delivered a clear and witty keynote presentation to a room full of Pacific health professionals, researchers, academics and doctors. It highlighted synergies and similarities between Māori and Pacific health, although Durie was cautious to avoid saying that what works for Māori communities will work for Pacific communities.

Durie spoke about the three principles of health research: whakapiri (engagement), whakamarama (enlightenment), and whakamana (empowerment). He noted that the whakamana or empowerment from research cannot take place successfully without whakapiri and whakamarama.

The concept of **whakapiri**, also known as talanoa or kakala, was a method that many Pacific researchers have adopted. The concept of talanoa is not new, however, what is new, is that western methodologies have been incorporated within our heritage and traditional methods such as talanoa. With the goal of improving engagement with our people, our cultural frameworks have been used to transform mainstream processes into something that will work better for Pacific people. Furthermore, talanoa has been packaged and branded into a process which our people understand and feel a part of. Talanoa provides a means of exchange for reciprocal learning and transfer of knowledge between researchers and participants, and enables researchers to view the participants as partners in research. Importantly, talanoa ensures that community priorities and research priorities are in alignment.

**Whakamarama** embodies the concept of “bringing light to where there is darkness”. Research is most effective when it is understood by both the Pacific community as well as academics. Enlightenment comes from empirical research, application of methodologies derived from indigenous knowledge and group discussions around research processes and findings. When Pacific communities and researchers are wiser, there is a greater collective understanding of Pacific communities, a greater appreciation of sciences as well as Pacific insights and we are more aware of the future possibilities, we can be sure that the research has achieved whakamarama.

**Whakamana**, or empowerment, requires health research to be informative, useful and uplifting. The most important change is that the research is translational and able to be translated into action as it relates to and will benefit our Pacific people. The research should be a cornerstone for advocacy to improve Pacific health outcomes; provide evidence for the development of policies that will have a positive impact on our Pacific people; encourage us to be courageous to use the research to trial, implement and test innovations that will work for our people; and provide opportunities for sustainability, so that our people are not over-researched. At present, it is difficult to say that our health system is empowering when Pacific health outcomes paint a gloomy picture. The task of researchers is to create evidence to facilitate a systems change, so that Pacific people can feel empowered.

Research is judged based on its impact, what it can achieve, and whether or not it will make a difference for Pacific people. The overall goal for Pacific health research should be its ability to transform research into action, so that health disparities for Pacific people are eliminated. Research is an opportunity to strengthen Pacific peoples’ struggle for equity, and in particular to achieve health equity and provide evidence for advocacy and change. Research should not be done in isolation; it can only have an impact wherever alliances exist and when research priorities are in alignment with those of Pacific people, conducted in partnership with Pacific people.



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## Pasefika well-being: Our uniqueness, our connections

**Presenter:** Ms Maiava Carmel Peteru

**Summary:** This presentation described the development of a Samoan conceptual framework that addresses violence in Samoan families and communities. This framework is one of seven ethnic-specific *Nga vaka o kāiga tapu Conceptual Frameworks*, which are underpinned by foundational core values and principles of Samoa, Cook Islands, Tonga, Fiji, Niue, Tokelau, and Tuvalu cultures. Since 2011, seven course programmes informed by the Conceptual Frameworks have been developed and piloted. The course programmes are specifically designed to build ethnic-specific Pasefika workforce capacity and capability. The launch of the *Nga vaka o kāiga tapu: Pasefika Proud Family Violence Research Plan 2013–2018* promotes and supports Pasefika community ownership and action to address family violence. The presentation highlighted the process taken to achieve depth in the Samoan conceptual framework: *O le tōfā mamao*. It went on to explore the natural synergies and the complexities that play a significant role in the connections between the seven conceptual frameworks.

**Comment (Leitu Sa):** *O le tōfā mamao* is a Samoan conceptual framework designed to address violence in Samoan families and communities living in New Zealand. *O le tōfā mamao* requires an understanding of the Samoan worldview and conceptual frameworks. It is based on Samoan core values and principles such as *vā* (space), *āiga* (family), and *fa’aaloalo* (respect). These core values are the essence of *fa’asamoa* with its conceptual understanding central to the *o le tōfā mamao* framework.

The complexities in translation, interpretations and assumptions made about Samoans not only hold true in a family violence context but also in the everyday lives of Pacific peoples, as we try to navigate and find our place in New Zealand society. Remembering who we are, where we come from and our place of belonging helps us better understand our uniqueness and our connections to each other. Our history, personal and familial knowledge and worldviews have shaped our past and will define who we will become in the future. As an Island-born Samoan, raised mostly in New Zealand, *o le tōfā mamao* challenges me to think about my family’s history and the traditional practices and beliefs that bind me and my extended family together. After listening to this presentation, I asked myself about its meaning, and how these concepts and values relate to me. I also began to reflect on how interpretations of Samoan concepts have changed, as we have become more westernised and immersed into New Zealand culture and taken on kivi or half-caste identities. This led me to consider that we risk losing the concepts of *fa’aaloalo*, *vā tapuia* (sacred relationship), *fa’asinomaga* (belonging and identity) and *gafa* (genealogy), if cultural knowledge and *fa’asamoa* is not maintained and passed on to younger generations. By acknowledging and understanding *fa’asamoa*, we will be able to support our Samoan families and communities to grow and flourish.

*O le tōfā mamao* highlights that *fa’asamoa* is unique and based on special relationships amongst individuals, whether these be between parents and children, spouses, grandparents and grandchildren or the most *vā tapuia* between brother and sister. One significant cause of violence and violations in Samoan families is when the *vā* relationships become blurred. Historical events, including the settlement of missionaries in Samoa, biblical references to male domination in the household, and the brother-sister covenant, all play a part in the understanding of violence in Samoan families. A central theme amongst all this is that every Samoan person exists in a *vā* relationship that is bounded by *feagaiga* (covenants). Furthermore, our connectedness to our families and culture is critical to our sense of identity and therefore critical to any framework that is created for the purpose of improving health, social or educational outcomes for Pacific people.

*Tapu*, *vā* and *āiga* are concepts that are well understood throughout the Pacific nations. However, the multiple contexts for these concepts are unique; they are performed and understood differently, according to local beliefs and values. Non-Pacific people who lack Pacific knowledge will incorrectly label Pacific populations as homogenous. This aspect underlines why rethinking, understanding and correctly interpreting Samoan concepts is crucial.



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## Cancer incidence rates among Native Hawaiians and Samoans in the United States, 2000–2010

**Presenter:** Dr Sela Panapasa

**Summary:** This presentation presented an analysis of recent trends in cancer incidence among Native Hawaiians and Samoans living in Hawai'i and California between 2000 and 2010, using incidence data from the US National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program. Age-adjusted analyses reveal significantly higher cancer incidence rates among Native Hawaiians living in the state of Hawai'i than rates among those living in the state of California. Moreover, markedly different outcomes were observed for both the incidence and risk of cancer. Similar results were found for Samoans, although to a lesser degree. The presentation pointed out that while most Native Hawaiian and Pacific Islanders (NHPI) tend to reside in tight neighbourhood-based communities in Hawai'i and California, health, educational and economic resources can vary between the two states.

**Comment (Dr Corina Grey):** For a long time, health statistics for Pacific people in the United States was aggregated with Asian Americans, rendering it uninterpretable. However, following a revision to ethnic categories for federal data collection at the turn of the century, NHPI became a distinct category, enabling disaggregation and allowing for more meaningful Pacific health data analysis in the US.

Dr Panapasa's research group utilised these disaggregated categories to explore the relationship between cancer incidence and place in Native Hawaiians and Samoans, the two largest Pacific subpopulations in the US. They found marked differences in cancer incidence, not only between Native Hawaiians and Samoans, but also between Native Hawaiians living in California and those living in Hawai'i. Their results underscore the importance of examining, where possible, health data by Pacific-specific ethnic group, as well as looking at geographical differences within groups.

Here in New Zealand, there are seven major Pacific groups, and if the number of subjects in a study is large enough (and time and resources allow), it would be worthwhile reporting at least some results by Pacific-specific group. Reporting results in this way would not only acknowledge the diversity of Pacific people in New Zealand, but it would also be a way of checking that there were no significant differences between groups that would necessitate interventions targeted at particular subgroups.

## Navigating female cancers, illness experience and health-seeking behavior in Tonga: Indigenous articulations of health, culture and modernity

**Presenter:** Ms Patricia Fifita

**Summary:** Key findings were discussed from qualitative research that is focusing on female cancer experiences, health-seeking behaviour and medical pluralistic pathways taken to obtain health care services in Tonga. An ethnographic approach has been employed to explore indigenous articulations of health and disease among cancer patients, survivors, and their families. Surveys have combined qualitative and quantitative research methods in order to examine disease experience and document health care decisions surrounding cancer treatment. This research will help inform the development of a culturally-centred cancer patient navigation programme aimed at increasing cancer education and improving access to appropriate cancer care in Tonga.

**Comment (Dr Corina Grey):** In this presentation, Ms Fifita, a Tongan anthropologist raised in the US, outlined her mixed methods research examining the female cancer experience in Tonga. Two important points from her presentation stood out as worthy of comment.

Firstly, Ms Fifita talked about the dearth of quantitative data on cancer incidence in Tonga, and although this is not a new problem, we do need to look at our own robust and systematic processes of identifying cancers in New Zealand, and consider ways in which it can be most efficiently used to improve health outcomes for Pacific people. For example, have we identified where the burden of disease is greatest in Pacific people and where we can intervene most efficiently? Also, given that these robust cancer reporting systems are now well-established in New Zealand, how can we help our Pacific neighbours to improve data collection and knowledge in both cancer epidemiology and more generally? Without data, there is no way of knowing the extent of a problem, or what should be done to address it.

Secondly, Ms Fifita's qualitative research showed that Tongan women with cancer utilise both Western and traditional medicine treatments. She argued that a cancer patient navigation programme in Tonga should therefore incorporate both a multidisciplinary and holistic approach, recognising that health, wellbeing and illness cannot easily be separated. Although more local research would be needed, it does seem that this advice is sensible and would translate well to a New Zealand setting for Pacific women.

## Pacific aspirations and determinants of health in a global context

**Presenter:** Professor Keawe'aimoku Kaholokula

**Summary/Comment (Dr Nuhisifa Seve-Williams):** In his keynote address, Professor Keawe'aimoku Kaholokula talked about Pacific aspirations for good health. He described five principles as being key to good health:

1. Mo'omeheu: Maintain a strong Pacific cultural identity and connection.
2. Ho'omana: Spiritual well-being serves as the focal point for physical, emotional, and social well-being.
3. Ho'opili: Interdependency facilitates positive socio-cultural and socio-economic development by maintaining strong families and communities.
4. Ho'okahua: Living in healthy and vibrant communities with access to healthy lifestyles and cultural institutions.
5. Ho'opi'iAlaka'i: Pacific leadership and participation across all sectors of society.

However, this presentation also stressed the fact that Pacific peoples face a number of challenges, including racism and deprivation, which are associated with risk for physical and mental health problems. In addition, negative stereotypes and assumptions held by mainstream adversely affect the health and well-being of Pacific peoples.

Professor Keawe'aimoku described how globalisation is creating larger gaps between socio-economic classes, spreading capitalism and individualism, and forcing migration from island homes. Globalisation is also responsible for creating social policies that do not align with Pacific aspirations, discrimination that is resulting in inequities in education, housing and employment, as well as limited resources and unequal resource distribution.

Despite these real challenges, Keawe pointed to a number of research initiatives that are bringing about progress and change. Examples included the creation of tools by Sam Manuela enabling us to measure Pacific identity and well-being, and research examining how the strengths and assets of Pacific Peoples and communities facilitate health and well-being. Moreover, he stated that Pacific aspirations can help guide the development of practical solutions, and that Pacific values and practices can be effective strategies to assist with health promotion.

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## The burden of Injury among Pacific peoples

### Presenters:

Dr Josephine Herman (The role of alcohol in four-wheel motor vehicle crashes in Fiji)

Dr Iris Wainiqolo (Association of kava with motor vehicle crashes and other injuries: A systematic review)

Wesley Lagolago (Increased incidence of traumatic brain injury in Pasifika: A profile of those people at risk)

Tainafi Lefono (Information needs and cultural issues of importance for Pasifika peoples following a spinal cord injury)

**Summary/Comment (Dr Josephine Herman):** The burden and risk factors for injuries among Pacific peoples in New Zealand and the Pacific region are a significant but poorly quantified and neglected public health problem. The presentations by Herman, Wainiqolo, Lagolago, and Lefono are a contribution to the knowledge of injuries among Pacific peoples in New Zealand and the Pacific region, highlighting some of the key risk factors as well as the need to take into account cultural contexts that influence recovery.

Although high-income countries have designed preventative measures to address established risk factors for road crash injuries such as alcohol, speed, seatbelt and car restraint use, and poor visibility; in poorly resourced settings such initiatives have been difficult to implement. This includes Pacific Island countries and territories where most roads are poorly designed (ill-lit and poorly maintained, unpaved) and legislative measures are limited and not well enforced.<sup>1</sup>

The Traffic Related Injury in the Pacific (TRIP) research undertaken by the Fiji National University in partnership with the University of Auckland is pioneering injury research in the Pacific region. As part of TRIP, the study conducted by Herman et al. is the first epidemiological study to quantify the role of alcohol in motor vehicle crashes in the Pacific. It estimated a three-fold increased risk for those drivers reporting they had recently consumed alcohol. Regarding kava, a root-based beverage with anxiolytic and sedative properties widely consumed in Fiji and some Pacific islands, the systematic review undertaken by Wainiqolo et al. found that there are no published studies that have investigated the role of kava in motor vehicle crashes. While the TRIP study is investigating the contribution of kava to motor vehicle crash injuries, the study is also one of a few worldwide which have quantified the risk of driver sleepiness in a low- and middle-income country (Fiji).<sup>2</sup>

Of the 69 Pacific Traumatic Brain Injury (TBI) cases identified in the Brain Injury Outcome in New Zealand In the Community (BIONIC) study (Lagolago et al.), a third each were due to falls (35%) and sports injuries (32%). This compares to the TRIP study on fatal and hospitalised head injuries in Fiji, where the leading causes of head injuries were road traffic injuries (40%), falls (30%), and being hit by a person/object (27%).<sup>3</sup> Understanding the drivers for the differential distribution and outcome of head injuries among Pacific populations in New Zealand and the Pacific region are important when developing preventative and responsive health and rehabilitative services. As suggested by Lefono et al., such services should also consider the cultural settings and norms that govern Pacific populations, including those recovering from spinal cord injuries.

1. World Health Organization. *Global status report on road safety 2013: supporting a decade of action*. Geneva: World Health Organization; 2013.
2. Herman J, et al. Driver sleepiness and risk of motor vehicle crash injuries: a population-based case control study in Fiji (TRIP 12). *Injury*. 2014;45(3):586-91.
3. Kool B, et al. Hospitalised and fatal head injuries in Viti Levu, Fiji: findings from an island-wide trauma registry (TRIP 4). *Neuroepidemiology*. 2012;38(3):179-85.

## How do Pacific patients with acute coronary syndrome in New Zealand compare with other patients?

### Presenter: Dr Corina Grey

**Summary:** This presentation described outcomes of research highlighting significant differences in the profile of acute coronary syndromes (ACS) patients in New Zealand. The researchers linked national hospitalisation and mortality data to identify all New Zealand residents who were admitted to hospital between 1 December 2008 and 30 November 2010 with an ACS as their primary diagnosis. Over this 2-year period, there were 25,988 ACS hospitalisations in 23,000 unique patients: 3% of patients were Pacific, 9% Māori and the remainder European/Other (with Europeans comprising >90% of this last group). The analyses determined that at the time of admission, Pacific and Māori patients tend to have a greater number and/or more severe comorbid conditions than patients from other ethnic groups. Scores on the Charlson Comorbidity Index classified 33% of Pacific patients, 30% of Māori patients and 19% of non-Māori non-Pacific patients as having a 'very severe' comorbidity burden. In particular, Pacific and Māori patients with ACS were found to have higher rates of previous hospitalisation for conditions such as congestive heart failure, chronic lung disease, diabetes with end-organ damage and renal failure. Nonetheless, despite these higher health needs, Pacific and Māori patients are less likely to be on long-term drug therapy after an ACS. About 55% of Pacific and Māori patients compared with almost 70% of Other patients were found to be receiving statins up to 3 years after an ACS hospitalisation. After adjusting for factors such as age, gender, diagnosis and cardiovascular history, Pacific people are 18%, and Māori 12%, less likely to be using statins after an ACS. Following an ACS hospitalisation, Pacific and Māori patients are at increased risk of death in both the short- (28-day) and long- (1-year) term. After adjusting for age, gender, deprivation, diagnosis and cardiovascular history, Pacific people are 30%, and Māori 60%, more likely than other patients to die within 28 days of hospitalisation. After 1 year, both Pacific and Māori patients have twice the risk of non-Māori non-Pacific patients of dying after an ACS hospitalisation.

**Comment (Dr Debbie Ryan):** This presentation by Dr Corina Grey, about her PhD study is an important contribution to the topic of unequal access to care for cardiac conditions in New Zealand. The need to focus on the quality of health services received by Pacific peoples was raised in Tukuitonga's (2002) landmark study in the 1990s, which showed that although Pacific (and Māori) peoples had higher rates of coronary artery disease morbidity and mortality, treatment rates (for procedures such as coronary artery bypass grafting) were lower in both groups. The focus of research and debate in New Zealand since has been about whether the differences in outcomes for preventable ACS conditions are due to patient factors (co-morbid conditions, late presentation, non-adherence to therapies), clinician factors (non-adherence with evidence-based guidelines, inadequate explanation of available therapies to patients) or system factors (e.g., resources, institutional racism).

Corina's findings indicate that there is still much more to be done. While Pacific patients with cardiac conditions also have other serious medical conditions, they are less likely to receive evidence-based treatment (in the short- and long- term) and more likely to die following hospitalisation.

After the presentation, Corina was challenged by a senior epidemiologist that her findings implied that the problems were due to staff racism. This discussion led me to reflect that this level of discomfort is probably a (welcome) indication that the debate about care may be shifting, after years of "patient blame" to a more balanced consideration including clinician and system factors. The voice of Pacific patients would add an important (and to date still largely unheard) perspective.

  
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