Te ara o Manawataki Fatu Fatu—Kaupapa Māori and Pacific qualitative co-design hui to explore cardiovascular disease care for Māori and Pacific peoples in Aotearoa New Zealand

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ABSTRACT

AIM: Cardiovascular disease (CVD) inequities in Aotearoa New Zealand disproportionately affect Māori and Pacific peoples, who experience higher risk factors, hospitalisations and mortality than NZ Europeans. These disparities stem from the historical and contemporary effects of colonisation, including institutional racism, impacting access to healthcare and socio-economic resources. Despite guidelines for earlier CVD risk assessments (CVDRA), gaps in identification and management persist.

METHOD: The Manawataki Fatu Fatu (MFF) for Māori and Pacific Hearts in Unison for Achieving Cardiovascular Care in Equity Studies (ACCESS) is a Māori and Pacific-led research programme examining CVD inequities in Aotearoa New Zealand. This study presents phase three, focussing on qualitative co-design hui (meetings) across Aotearoa New Zealand to gather insights from Māori and Pacific patients, whānau (family/supports) and kaimahi (healthcare workers) engaged with CVD services spanning primary to secondary care.

RESULTS: A total of 105 participants attended four regional hui focussed on the heart healthcare experiences of Māori and Pacific peoples in Aotearoa New Zealand. Template analysis revealed four key themes for achieving equitable healthcare: the importance of the whānau/community, the need for providers to engage with patients at their level, the persistent barriers faced and a strong commitment to protecting Māori and Pacific communities and kaimahi.

CONCLUSION: This study is a comprehensive qualitative investigation into heart healthcare for Māori and Pacific peoples in Aotearoa New Zealand. The findings reiterate that care must align with the realities of Māori and Pacific peoples and that interventions must address long-standing systemic barriers to care.

Cardiovascular disease (CVD) inequities in Aotearoa New Zealand are evident in the health outcomes of Māori and Pacific peoples who face disproportionately higher rates of CVD risk factors, hospitalisations and mortality compared with New Zealand Europeans.[1,2] Most concerning is the premature onset and mortality from CVD among Māori and Pacific peoples.[3,4] These inequities are not coincidental but are instead rooted in the legacy of colonisation, which continues to be perpetuated through intergenerational institutional racism. This has resulted in systematic inequities across socio-economic determinants of health, including income, housing and education and manifests in reduced access to primary care and guideline-defined medical therapy for Māori and Pacific communities in Aotearoa New Zealand.[5]

Recognising these inequities, the Aotearoa New Zealand CVD primary prevention guidelines recommend earlier CVD risk assessments (CVDRA) for Māori, Pacific and South Asian peoples.[6] However, a recent systematic review highlighted significant gaps in CVDRA and management across all CVD care pathways for Māori and Pacific peoples in Aotearoa New Zealand.[5,7] Opportunities for reducing these gaps include providing adequate CVD literacy, involving whānau, fostering good patient-provider relationships, ensuring access to care and enhancing cultural safety. Therefore, the findings of this study will inform the creation of an equity roadmap for Māori and Pacific CVD care.[5,8]

The Manawataki Fatu Fatu (MFF) for Māori and Pacific Hearts in Unison for Achieving Cardiovascular Care in Equity Studies (ACCESS) is a critical response to the known gaps in care. Launched in 2020, this Māori and Pacific-led mixed-methods research programme aims to investigate and address CVD inequities in Aotearoa New Zealand.[9] Following previous meetings and research with Māori and Pacific stakeholders, clinicians and researchers, it was cited that an integrated approach, incorporating both qualitative and quantitative methods that interrogate the available data and capture the stories of Māori and Pacific communities, their whānau and the wider community was required.[9] This study explored the experiences of Māori and Pacific peoples with CVD care in Aotearoa New Zealand by gathering insights from patients, their whānau and health workers involved in the complete care continuum, from primary care to secondary care.

Methods

Methodological stance

Kaupapa Māori and Pacific research methodologies informed this study, and the full methodological approach has been described and published.[9] This study was guided by governance and leadership provided by Māori and Samoan principal- and co-investigators, who oversaw a predominantly Māori and Pacific research team.[10–12] A co-design approach fostered community partnerships, aimed at systems-level change and improved equity for Māori and Pacific peoples. He Pikinga Waiora, a co-design framework for health intervention development, implementation and evaluation was utilised.[13] This framework emphasises cultural centeredness, community engagement, integrated knowledge translation, and systems thinking. The Fa'afaletui framework also guided the process, providing decolonising guidelines for reciprocal relationships between researchers and communities.[14] The Auckland Health Research Ethics Committee approved this study on 23 June 2021 (AH22609).

Māori and Pacific scholarship capacity

The MFF programme collaborates with Māori and Pacific researchers across various career stages.[9] Senior Māori and Pacific researchers oversee the programme, while emerging researchers facilitate research hui with community organisations like Hāpai Te Hauora and Moana Connect, conduct data analyses and produce final reports. This integration enhances research experience, mentorship and Māori and Pacific scholarship capacity.

Hui

Four hui facilitated by the research team in partnership with community organisations—Hāpai Te Hauora and Moana Connect—were held.[9] Three in-person hui in Kaitāia, Lower Hutt and South Auckland and one virtual hui (Zoom) (South Island) were held between 12 April and 25 July 2024 (Figure 1). The in-person hui were run as all-day sessions ranging from 4–6 hours and the virtual hui was conducted over 2 hours. All patients and whānau received the final report upon request. A follow-up virtual hui was held to allow participants to provide feedback to the research team (Figure 2). Māori and Pacific qualitative researchers with experience in facilitating Māori and Pacific hui and talanoa, and applying co-design principles, coordinated the hui. Hui schedules were semi-structured and were centred on three key questions:

1. How do optimal heart health services look and feel?
2. How can we improve the patient journey for you and your whānau?
3. What must we do to get from where we are now to where we want to go?

Participants and recruitment

Māori and Pacific patients who experienced CVD care, along with their whānau and kaimahi, were purposefully recruited. Recruitment involved invitations to communities known to the MFF research team and healthcare facilities specialising in CVD care. Purposive sampling ensured diverse representation of age, gender and geographical location across the four regions in Aotearoa New Zealand. A participant information video, produced by Hāpai Te Hauora, was available alongside the information sheet and consent form, featuring captions and audio. Participants received a koha of NZ$200 in the form of petrol or supermarket vouchers.

Data collection

Each hui was audio-recorded, with consent, to capture kōrero accurately. Researchers recorded field notes, and photos were taken with permission from participants to capture discussions (Figure 1). Self-reported demographic information was also collected, and an artist was present at the South Auckland hui to capture the mood and atmosphere of the event.

Data analysis

Two researchers transcribed hui recordings and analysed the data using NVIVO 14 (Version 14.23.2).[15] They familiarised themselves with the data and created an initial coding template with *a priori* codes before applying it to the remaining transcripts and audio-visual texts.[15] The coding template was regularly revised to combine key themes identified *a priori* with new themes emerging *de novo*.[15] As new data were compared, the framework was refined, incorporating new codes and removing redundant ones. After analysing each of the four hui, a final report was sent to participants for feedback. A combined analysis of all four datasets produced the overall themes of this study.

Results

This study involved 105 participants and identified 18 themes across four hui, which were consolidated into four key themes. Separate reports were created for each region to honour the unique experiences shared and were returned to participants as requested (Figure 3).

1. Our village, our community, our whānau

This theme emphasises Māori and Pacific community values. Participants desired a culturally safe healthcare system with a responsive workforce, community connections and values like whānau, culture and equity.

> *"We want kaimahi with cultural intelligence working for us. Kaimahi who understand the meaning of equity and equity within the community. We want a system and services that do not operate in silos. A system that is connected to primary health, universities, hospitals, iwi, whānau and Pasifika. We want to be connected."* – South Auckland, Kaimahi Tāne 1.

Figure 1: Summary of regional hui and overview of participants.

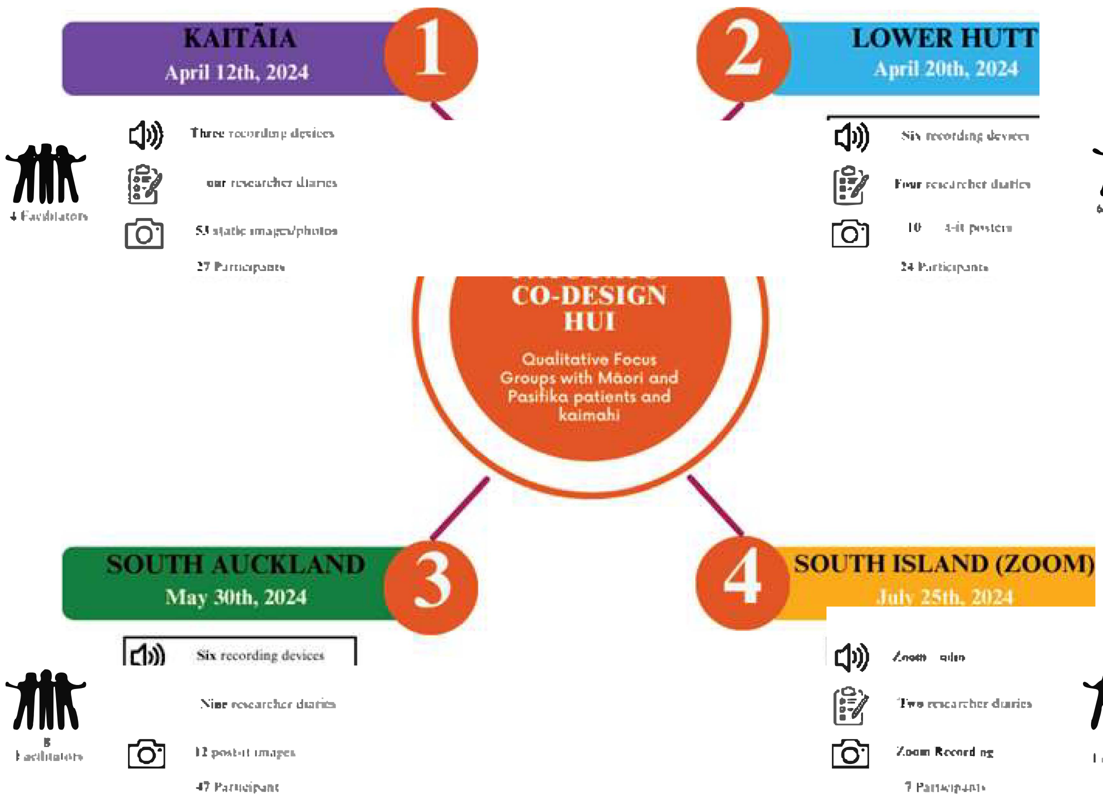
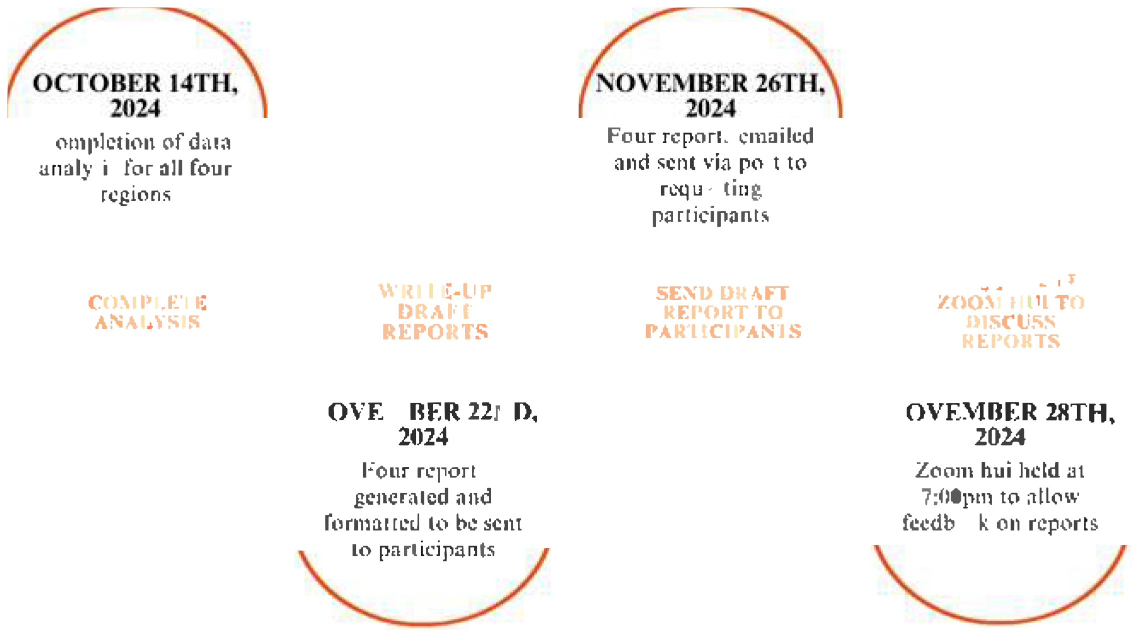


Figure 2: Dissemination strategy.



Pacific whānau emphasised the importance of their "village" amid challenges adapting to Aotearoa New Zealand life from the islands. They reflected that 4th generation Aotearoa New Zealand–born Pacific whānau have experienced changes in their socio-cultural context, yet family and community values persist.

> *"That's an attitude of us* [Pacific peoples], *who have just migrated. We still bring that village attitude here that you know if something goes wrong here, you want to go there. If you need help, that kind of thing. Whereas here* [in Aotearoa New Zealand], *it's different. You mind your own business, and you don't interfere with your next-door neighbour."* – Lower Hutt, Pacific 2.

The intergenerational family structure in Māori and Pacific communities emphasised by whānau and kaimahi highlights how connecting younger generations can support older members. This approach aligns with community cultural values. Whānau shared lessons from their heart health journeys, motivating them to educate themselves and ensure their mokopuna learn to maintain good heart health and avoid similar challenges.

> *"You start thinking about these things, and you start feeling vulnerable as if you never looked after yourself. So I will try to pass that on to my mokos. I sort of missed out with my children because I was too busy working. But my mokos, I try and pass on everything that I know so they don't make the same mistakes that I did."* – Lower Hutt, Kaimahi Tāne 1.

Engaging whānau in all aspects of care—from decision-making to recovery—is essential. Whānau members also reported needing support. Whānau play a vital role as advocates for heart health patients, helping them navigate the healthcare system. Empowering self-advocacy is key to enhancing patient and whānau agency.

> *"We found similar themes of needing in difficult times in the health system to learn how to, for our communities, learn how to be good advocates for themselves and the processes to learn how to become a good advocate."* – South Auckland, Kaimahi Tāne 2.

Participants also asserted that heart healthcare extends beyond the individual patient to encompass the entire family unit, reaffirming that whānau require wrap-around support, especially when caring for a loved one hospitalised with CVD.

> *"We did not get that support, and at that same time, we were trying to look after this baby. So, I felt that the holistic approach to care wasn't taken care of. So whilst my baby was sick, the stress level on me and my husband and my other two children, that we're now part of this heart child, was intense."* – South Island, Pacific Wahine.

The lifestyle aspects of heart healthcare were widely discussed, including healthy homes, a balanced diet, regular exercise and a suitable job. However, these were only raised following extensive talanoa about family, identity, culture and values. Māori participants extensively discussed tino rangatiratanga (self-determination).

> *"Eating healthy and not smoking, vaping, drinking alcohol are all acts of resistance. Those are all acts of tino rangatiratanga. Start with ourselves. Meanwhile, we need all the health support too, but actually teaching our kids... Our Hauora could look like paddling waka ama, touch, kapa haka or could look like a raranga group. If we were doing raranga together or gardening, we could also learn about oranga whānau—all those kinds of things. We have to kill the racism though; it's got to go. It's the systemic stuff."* – Kaitāia, Wahine 5.

The current "system" is considered unacceptable due to recent pressures that are worsening already existing culturally unsafe and racist practices. In this light, rather than waiting for the system to be replaced or changed, whānau Māori described needing to take charge now.

> *"I think the biggest thing is that you have to be your own advocate. You have to take control of your health because really, honestly, nobody else is going to do it for you."* – South Auckland, Wahine Māori 4.

Participants emphasised the need for a culturally safe healthcare system that values community and whānau involvement. They called for a culturally intelligent workforce that respects individual autonomy while meeting community needs. Addressing the unique challenges of Māori and Pacific communities requires intergenerational learning, caregiver support and practical lifestyle interventions. Ultimately, heart healthcare should combine clinical excellence with cultural and familial foundations.

2. Nothing new

Numerous barriers and gaps in heart healthcare were identified, spanning areas such as CVDRA, discharge planning and transitioning from hospital to community care. This theme voices the frustration of patients, whānau and kaimahi about systemic racism and colonial values in healthcare. Shared experiences of culturally unsafe care have deepened mistrust and created barriers to accessing heart healthcare.

> *"Sometimes the interactions with doctors and nurses and other kaimahi are the interface* [through which] *we interact with the health system, and if that interface is not very good and the communication is poor, that really turns people off. And also ... we're good at detecting bias and racism. We've all lived that experience, and when we detect it from the other side it undermines our trust in the system."* – South Auckland, Kaimahi Tāne 4.

Upon hearing this feedback, kaimahi were determined to hold themselves and their colleagues accountable. This was enshrouded in the notion that central to Māori and Pacific communities are their whānau, village and community.

> *"We should not, as providers, be hearing that kind of feedback from our community, our people, and it's my responsibility to make sure that I do better."* – Lower Hutt, Kaimahi 1.

Participants emphasised the need for systemic approaches by healthcare providers and policymakers to create an equitable and culturally safe healthcare system for Māori and Pacific communities. They noted that healthcare practitioners are the key link between health services and these communities and again expressed a desire for more Māori and Pacific kaimahi to provide care.

> *"There's not enough of us in the system. So, whatever we can do to encourage more whānau to be involved in nursing or with doctors. Now, a lot of whānau are becoming doctors, but that was one thing that would, to me, make it better."* – South Island, Tāne Māori.

Discussions on critical shortages in primary healthcare were prevalent in all hui, focussing on cost, travel and access barriers. The inability to enrol with a local general practitioner (GP) was concerning, leaving participants and whānau feeling uneasy about that state of our healthcare system.

> *"Very often they still take up to 2 weeks to get an appointment, and I know when I was at Middlemore, especially during flu season, you just can't get to your GP. So all of these things, time, after hours, you know, it's really hard."* – South Auckland, Pacific Tāne 3.

Issues regarding the postcode lottery and subsequent food/alcohol/vape swamps were raised in all four regions. In Kaitāia, the concentration of vape and liquor stores has been an enduring concern among community members.

> *"I have not counted yet, but there are between nine and 15 vape shops on the main street in Kaitāia ... that stuff is literally poisonous, so the companies have moved from tobacco to vaping. They're pushing that new stuff ... vapes. We don't even know what's in that, but it won't be anything good."* – Kaitāia, Wahine 7.

Many valuable insights were shared regarding participants' desire for self-determination in their heart healthcare. However, addressing systemic barriers such as food, vape and liquor shop swamps must happen simultaneously. While facing many obstacles, including culturally unsafe or unpleasant interactions with healthcare providers, one participant described their desperation of going through six doctors before being heard.

> *"There is not enough information for new patients going through the heart experience for families to understand what's going on. We have a family of five, plus we have raised other kids, so our home has never been a home. It's always been a marae. So, to school our children up with what their father is going through, we couldn't explain that. 'Cause we didn't even know. We went through six doctors before we were able to find a doctor that would listen."* – Lower Hutt, Whānau Wahine 1.

Māori and Pacific kaimahi described overwhelming experiences of interpersonal and institutional racism coupled with the staggering amount of cultural loading.

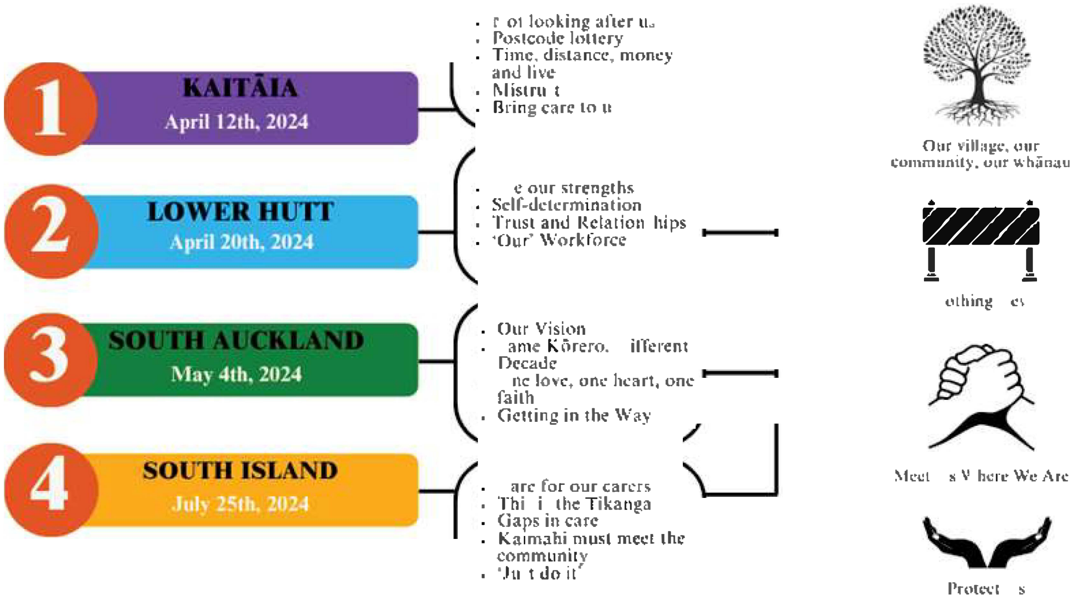
> *"I think the biggest barrier we have here is our own* [Pākehā]*... They are the biggest barrier. We can discuss this from experience. We throw around our overseas-trained* [staff]*, but I have found them to be the most open-minded. Whereas with our own, they're influenced by the racism that sits in this country. So they hold to that."* – South Auckland, Kaimahi Tāne 1.

Many experiences of racism were reported, and these were heightened in services and regions where a clear disconnect between the workforce and the community existed. Kaimahi were determined to push the responsibility of cultural safety training back onto non-Māori and non-Pacific providers as opposed to being further culturally loaded to provide this service in addition to their kaimahi roles.

> *"You know one of the doctors came up to me. She goes, 'we need some more of you* [Māori]*'. I thought to myself, no. You guys just need to get educated to have to look after our people because the education doesn't just come from me."* – South Island, Kaimahi Wahine 1.

This theme highlights ongoing challenges faced by whānau in accessing heart healthcare due to culturally unsafe systems, racism and systemic barriers. It emphasises the struggles of kaimahi who advocate for their whānau, often neglecting their own wellbeing. Participants pointed out the lack of Māori and Pacific healthcare workers and called for better representation and a more responsive system. The theme also outlines

Figure 3: Roadmap of themes drawn from all four hui.



the impacts of these barriers, including loss of lives and resources, compounded by long travel distances and limited cardiac services.

3. Meet us where we are

Participants showed enthusiasm for promoting heart healthcare in their communities. The theme “Meet us where we are” stresses the necessity for healthcare providers to connect with communities culturally. It aims to bridge Western healthcare and Māori and Pacific communities. Building trust between patients and providers involves creating safe spaces that embrace familiar cultural practices.

> *“But we’ve shared, I think, really in our discussions today, that it is about making sure that our spaces are familiar and are relevant to our people. Make it a space where they can feel comfortable coming in. And it’s not just clinical, but we might offer them some kai. We might offer them some really good music.”* – Lower Hutt, Kaimahi Tāne 1.

Secondly, bringing care to the community was also essential to bridge gaps.

> *“Having a remote heart health clinic that goes out to marae, goes out to the people. Actually goes out to see them instead of them coming in to see us. Having mobile clinics where we can go out and do echocardiograms, blood tests and electrocardiograms, especially in remote areas … to be able to provide the standard of care that should be given across the board and not just be given in the bigger areas. Earlier support for the heart patient before they have the heart attack and if someone has high blood pressure or angina they get referred instead of waiting until they have a heart attack or have heart failure.”* – Kaitāia, Kaimahi 4.

However, having healthcare providers who look like and relate to them made participants feel safer and “like they belonged”. As kaimahi, witnessing and being acknowledged by Māori patients significantly fostered a sense of belonging.

> *“I remember this young Māori man from out of nowhere. And when he saw me, it made all the difference when I was there with him because everyone else is not Māori.”* – South Auckland, Kaimahi Tāne.

To realise aspirations such as equity, advocacy, Māori, Pacific and whānau-centric care, healthcare providers, leaders and managers must institute genuine cultural safety training programmes and levers with a specific focus on upskilling non-Māori and non-Pacific healthcare providers. One kaimahi referred to the notion of non-Māori and non-Pacific providers doing some of this "heavy lifting" with respect to creating culturally safe and equity-centred heart healthcare.

> *"Something like changing the governance structure. Maybe that comes down to cultural-safety-training upskilling our non-Māori non-Pacific health workers in terms of cultural safety. You know, there are only so many of us who can do that work. We really need to use those who are not Māori and Pacific, who've got a Māori and Pacific heart."* – South Auckland, Kaimahi Wahine 3.

To ensure care for patients and whānau, it was essential to create a sense of "home". Supporting the healthcare workforce in Kaitāia was a priority, with examples given from other industries attracting Māori to healthcare. Keeping local healthcare providers involved included bonding to retain the local workforce.

> *"We should invest in our own doctors, in our own resources. So, we need the resources in Kaitāia ... training our doctors and nurses here in Kaitāia. Invest in our own so that they stay here and they are not allowed to go anywhere!"* – Kaitāia, Tāne 4.

In Lower Hutt, Māori and Pacific kaimahi shared that in their experience, having a fit-for-purpose workforce with predominantly Māori and Pacific kaimahi facilitated stronger connections and acceptability within and by whānau.

> *"The number one thing for us is that we have staff that look like the people we serve. So Māori, Pacific, refugee staff so that when our whānau come to the clinic, they see people that look familiar, and they feel like we are there to help them. The people we employ reflect the community that we serve."* – Lower Hutt, Tāne 8.

Theme three recognised that smoother transitions between care facilities, particularly from hospitals to community settings, are needed. Key elements included medication reconciliation and follow-up. A digital health passport—a personal health record digital application for patients with long-term conditions that tracks and shares care plans—was raised as a potential solution.

> *"So when you get there* [to hospital/clinic], *you say chur, instead of mucking around the bush. They know you've got a heart problem... Why have a heart attack when you've got to wait in line for nearly 4 hours? You'd be dead by the time you got in there."* – Kaitāia, Tāne 7.

While most participants acknowledged the benefits of digital health and its advancements in heart healthcare, they also reflected on the need to ensure that these advancements did not create further barriers.

> *"... especially with social media. I know with our people, it's a bit hard to access... So you have to look at other ways to reach our community, especially with English as a second language."* – South Island, Kaimahi Pacific Wahine.

In summary, this theme showcased where kaimahi are already making changes to bridge the gaps described earlier in theme two. These include growing the Māori and Pacific health workforce and adopting new approaches to delivering and receiving healthcare with the premise that no one should be left behind.

4. Protect us

Participants advocated for healthcare that was safe, urging kaimahi to protect Māori and Pacific communities from harm. Achieving this necessitates a culturally safe, responsive and compassionate workforce. Building trust and relationships is essential, which can be expedited by providers reflecting the communities whom they serve.

> *"As a provider, you need to tap into that skillset there because they are the springs of that community. They have a relationship with the people that you want to bring into the talanoa... Change the model of connecting to the community."* – Pacific Tāne 7.

There was a strong sense by whānau that having a Māori or Pacific GP meant you were more likely to get what you needed out of the consult, be it referrals, culturally relevant advice and even straightforward but significant things like having your name pronounced correctly.

> *"Just that little bit of time makes a huge difference to everyone, to predominant culture patients as well as Māori, but especially for Māori and Pacific. We like to have that little moment of mihi before the process, or whatever the treatment might be, begins."* – South Island, Kaimahi Tāne 1.

Whānau Māori suggested improving access to healthcare training placements in Māori communities and increasing early community placements for new doctors. While it is preferable that these placements would target and support Māori and Pacific graduates, it was emphasised that achieving health equity for Māori and Pacific communities is everyone's responsibility, not just Māori and Pacific providers.

> *"Maybe those registrars and house officers could be coming out... Yeah, but I'm just thinking of going to those groups, going to these places, 'cause they are always doing some really good research out there."* – South Auckland, Wahine Māori 2.

Implementing legacy-building processes fosters connections, or whakawhanaungatanga, between healthcare providers and their patients. This strengthens engagement and helps providers understand their communities' needs and rights, while maintaining trust. Established trust enhances collaboration in and support towards research. Participants expressed a desire to conduct their own research to ensure relevance and cultural safety.

> *"We need more Māori and Pacific research that redefines our values for heart health... Māori and Pacific studies going into understanding the heart so we can reference our own, you know when treatment comes in, diagnosis, it's purely from a biobank of just Māori and Pasifika."* – South Auckland, Wahine Māori 2.

This reaffirmed the need to adapt heart healthcare pathways to the lived experiences and socio-cultural contexts of communities. Participants asserted that all healthcare providers must demonstrate compassion, regardless of their background.

> *"She's a European, and she comes into the centre once a week ... and it's good because she's in environments with other Pacific Island and Māori and we can see the compassion. I think that's the word that's missing. You can become a professional, but if you're not compassionate, you miss it all."* – South Island, Pacific Tāne 1.

Similar to theme two, this theme also promotes the protection of Māori and Pacific kaimahi. Many kaimahi reported significant cultural loading and stressed the importance of adequate care and support.

> *"We could have a Māori network at* [redacted] *that would be so much stronger. If we call a hui and say we want to have a Māori network, then we can draw on each other and awhi* [support] *each other because we can't do it alone in our little areas because it's too difficult."* – South Auckland, Kaimahi Wahine 4.

Finally, a wero (challenge) was laid before the research team to ensure ongoing research is directly translatable and monitored to see if it makes an actual difference.

> *"So, this particular piece of research is only funded for a specific time. For our whānau sitting here, you know, is it going to make a difference? It's a huge question. Is it going to make a difference for us, for our generation and the generations to come?"* – Kaitāia, Kuia 1.

The research team was encouraged to advocate for action based on our findings, rather than conducting more research that is not translational. Whānau and kaimahi expressed a "no need to apologise, just get it done!" attitude towards implementing change using Māori and Pacific-specific stories.

> *"There is always a reason why it can't happen. You have to stop letting the system or the pathway dictate what*

> *to do; you just gotta go and do it!"* – South Auckland, Kaimahi Tāne 1.

Kaimahi were also challenged by whānau about how healthcare providers and researchers engage with them to find solutions. The "gaze" was turned back on kaimahi to reflect on what needs to be done for Māori and Pacific whānau to be self-determining in their heart healthcare.

> *"Have you, the providers, ever asked yourselves the question, 'What can we do better' in order for the public to be receptive to what we are about to give?"* – Lower Hutt, Pacific Wahine 5.

Others reiterated that the physical components of living, such as having land to belong to and tending gardens for good nutrition, have been hindered by colonisation and that the state of Te Taiao (environment) also affects how well Māori can be. Protecting patients, whānau and kaimahi in heart healthcare requires an empathetic and culturally safe workforce aware of the barriers faced by Māori and Pacific patients. Researchers must engage with these communities and be accountable for their work. Māori and Pacific representation as kaimahi fosters trust in Western healthcare settings. The need for culturally aligned healthcare providers underscores the importance of authenticity and connection with Māori and Pacific communities.

Discussion

Our study includes views from 105 Māori and Pacific patients, families and healthcare workers on heart healthcare. Using a Kaupapa Māori and Pacific approach, we identified four key themes: the importance of whānau/community, the need for providers to understand patients' contexts, ongoing barriers and a commitment to protecting Māori and Pacific communities.

Participants outlined the barriers they experienced in their heart healthcare journeys and a shared vision of a culturally safe, whānau/community-centred and equitable healthcare system that protects them in their pursuit of better heart health. These are not entirely new and exclusive to heart healthcare; however, they are consistent with related studies involving Māori[16–19] and Pacific peoples.[20–21] Overall, whānau proactively developed solutions to address the numerous barriers impeding their heart healthcare journeys. Brewer et al. reported that Māori and Pacific whānau who had experienced cardiovascular care were affected by the social determinants of health and experienced being deprived of accurate information about their condition and its management.[17] Achieving equity in heart healthcare and outcomes requires addressing the contextual factors, including the social determinants of health, fostering effective two-way communication that stems from strong provider-community relationships, and empowering individuals to take control of their heart health.[17,22]

The MFF research initiative addresses colonial aspects of co-design by being led by Māori and Pacific communities, promoting their advancement.[9] King argues that the co-design methodology reinforces whiteness by (re)producing white experts and white ways of knowing.[23] Government organisations have used these methods paternalistically towards Māori, portraying Indigenous peoples as "infantile" and undermining the value of Indigenous knowledge.[23] Utilising Kaupapa Māori and Pacific methodologies minimises the risk of further colonisation through research, while empowering transformative agency and aiming for equal power distribution between patients and providers.[24–25] In our hui, we divided participants into Māori whānau, Pacific whānau and kaimahi groups to present insights, recognising that Indigenous peoples are connected in a holistic network to their history, each other and their environments.[26] These relationships are primarily rooted in whakapapa (genealogy): an extensive and ever-evolving network of connections.[26–27] Additionally, some participants spoke from both provider and patient levels, offering valuable insider-outsider perspectives.[27]

In conclusion, this study is one of the most extensive qualitative studies conducted to date in understanding and improving heart healthcare for Māori and Pacific peoples in Aotearoa New Zealand. By utilising a combined Māori and Pacific methodological approach grounded in the foundational principles of the MFF programme, four regional hui facilitated the successful involvement of 105 Māori and Pacific patients, along with their whānau and kaimahi from different regions in Aotearoa New Zealand.[9] In presenting the study, we acknowledge the limitations in (re)presenting combined views of Māori and Pacific peoples and the potential dilution of unique perspectives shared concerning culture, identity and local context. However, this study illustrates the strength of Indigenous-led, culturally responsive methodologies in generating robust qualitative evidence and provides a critical platform for informing policy, practice and future research aimed at advancing equity in cardiovascular health.

COMPETING INTERESTS

Nil.

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Appendix: Glossary

Kupu Māori or Pacific	**Translation**
awhi	Support
kaimahi	Māori or Pacific healthcare workers involved in CVD risk or CVD care for patients and their whānau (i.e., doctors, nurses, social workers, Māori/Pacific health liaison personnel etc.)
karakia whakakapi	Closing prayer
koha	Gift or token of appreciation (in voucher form for this study)
kōrero	Talk, discussion
hui/talanoa	Refers to a meeting and in specifically in this research refers to the four meetings held in the four regions of New Zealand
Māori	Indigenous peoples of New Zealand
mihi whakatau	Informal Māori welcome
mihimihi	Process of greeting/acknowledgement
mokopuna	Grandchild/grandchildren
oranga	To be well/wellness
Pacific	Indigenous peoples of the Pacific Islands (also referred to as Pacific peoples/ Pacific Islanders)
Pākehā	New Zealanders of European descent
paramanawa	Break
poroporoaki	Farewell
pōwhiri	Formal Māori welcome
raranga	Weaving
Te Taiao	Environment/natural world
tino rangatiratanga	Self-determination
waiata	Song
whakawātea	Exit song/item
whakawhanaungatanga	Process of making connections
whānau	Family/extended family or wider support persons including close friends