

# Māori Health Review™



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Issue 59 – 2016

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### Abbreviations used in this issue

NIS = National Immunisation Schedule



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## Greetings

Welcome to this issue of the Māori Health Review. Each issue attempts to bring you research relevant to the health and wellbeing of Māori. I welcome feedback and suggestions for papers/research to include in future issues and I'm pleased to hear and read about the excellent work being undertaken in Hauora Māori.

Nga mihi

**Matire**

Dr Matire Harwood

[matire@maorihealthreview.co.nz](mailto:matire@maorihealthreview.co.nz)

## Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review

**Authors:** Hall WJ et al.

**Summary:** This US-based study sought to determine the extent to which implicit racial/ethnic bias exists among health care professionals and examine the relationships between health care professionals' implicit attitudes about racial/ethnic groups and health care outcomes. The study explains that implicit attitudes are thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control. Such attitudes are often automatically activated and can influence human behaviour without conscious volition. A search of 10 computerised bibliographic databases identified 15 studies for review, almost all of which used cross-sectional designs, convenience sampling, US participants, and the Implicit Association Test to assess implicit bias. In 14 studies, there was evidence of low to moderate levels of implicit racial/ethnic bias among health care professionals; similar implicit bias scores to those in the general population. Levels of implicit bias against Black, Hispanic/Latino/Latina, and dark-skinned people were relatively similar across these groups. Although some associations between implicit bias and health care outcomes were nonsignificant, results also showed that implicit bias was significantly related to patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes. Implicit attitudes were more often significantly related to patient-provider interactions and health outcomes than treatment processes.

**Comment:** An excellent paper providing further evidence of implicit bias in healthcare; and the subsequent impacts on health outcomes. I'm interested in learning more about effective interventions.

**Reference:** *Am J Public Health. 2015;105(12):e60-76*

[Abstract](#)

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## Prospective surveillance of hospitalisations associated with varicella in New Zealand children

**Authors:** Wen SC et al.

**Summary:** Data from the New Zealand Paediatric Surveillance Unit (NZPSU) were analysed for this investigation into the hospitalisation burden of varicella. Cases (0–14 years) were defined as varicella and post-varicella complications requiring hospitalisation, including stroke syndromes where varicella occurred in the preceding 6 months, reported to the NZPSU between 1 November 2011 and 31 October 2013. Of a total of 178 notifications, 144 were confirmed cases. The hospitalisation rate was 8.3/100,000 children per year, with over-representation among Māori and Pacific Island (PI) children, who accounted for 74% of hospitalisations and both had significantly higher incidence rate ratios (2.8 and 3.9, respectively) compared with European children ( $p < 0.01$ ). Complications included infection (75%), respiratory (11%), neurological (11%), electrolyte disturbance (6%) and haemorrhagic varicella (4%). Nine percent were immunocompromised. Median duration of hospital admission was 4 days, with 9% requiring intensive care admission. There were no reported deaths; however, 19% had ongoing problems at discharge.

**Comment:** I know a few Māori whānau who, having experienced the significant morbidity that can occur with varicella infections (chickenpox) in their older children, self-funded the varicella vaccination for their younger kids. As the authors suggest, the inclusion in NZ's immunisation schedule has the potential to reduce health inequities between Māori and non-Māori children.

**Reference:** *J Paediatr Child Health.* 2015;51(11):1078-83

[Abstract](#)

## Trends in ethnic and socioeconomic inequalities in cancer survival, New Zealand, 1991–2004

**Authors:** Soeberga M et al.

**Summary:** These researchers assessed trends in cancer survival inequalities in New Zealand by ethnic and income group, in a cohort of 126,477 people diagnosed with cancer between 1991 and 2004 and followed to 2006. The analysis measured inequalities pooled over time with excess mortality rate ratios (EMRRs) and changes over time in those inequalities by using EMRRs, excess mortality rate differences (EMRDs) and absolute differences in relative survival risks (RSRDs); all three were estimated by cancer-site and (for EMRRs only) pooled across all sites. Pooled over time and all sites, Māori had an EMRR of 1.29 (95% CI, 1.24 to 1.34) compared to non-Māori. The low- compared to high-income EMRR was 1.12 (95% CI, 1.09 to 1.15). Pooled over cancers, there was no change in the ethnic EMRR over time but the income EMRR increased by 9% per decade (1–17%). Changes over time in site-specific inequalities were imprecisely measured, but the direction of change was usually consistent across EMRRs, EMRDs and RSRDs. Ethnic inequalities in cancer survival persisted over time, with slower improvements for low-income people.

**Comment:** Although the data is now a little dated, the message is alarming. As the authors recommend, constant vigilance of the health system's activity (or inactivity!) is required.

**Reference:** *Cancer Epidemiol.* 2015;39(6):860-2

[Abstract](#)

## Patterns of axillary lymph node metastases and recurrent disease in grade 1 breast cancer in a New Zealand cohort: Does ethnicity matter?

**Authors:** Meredith I et al.

**Summary:** Using data from the Auckland Breast Cancer Registry (ABCR) and the Waikato Breast Cancer Registry (WBCR), these researchers identified 2857 women newly diagnosed with grade 1 primary invasive breast cancer between 1 June 2000 and 31 May 2013. Almost one-fifth (19.0%) had axillary lymph node involvement, and recurrent disease (locoregional or distant) developed in 5.1%. Pacific and Māori women were more likely than NZ European women to have larger tumours and lymphovascular invasion (LVI). Predictors for axillary node involvement were tumour size  $> 10$  mm, LVI and non-screen detected cancers. Factors found to predict recurrent and/or metastatic disease were tumour size  $> 10$  mm, lobular carcinoma and breast-conserving surgery without radiotherapy. Ethnicity did not independently predict axillary nodal involvement, recurrent and/or metastatic disease, or breast cancer-specific mortality in this patient population.

**Comment:** Hopefully the results will get breast cancer services to focus on early diagnosis and better management rather than genetic differences.

**Reference:** *Cancer Epidemiol.* 2015;39(6):994-9

[Abstract](#)

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## One Whānau (Family) at a time/Una Familia a la vez

Author: Ehou N

**Summary:** This paper describes how Health Hawke's Bay-Te Oranga Hawke's Bay (HHB) is successfully working with existing community strengths to influence and build whānau health resilience among Māori in Hawke's Bay, whose rates of ischaemic heart disease, diabetes and breast cancer are substantially higher than for non-Māori. Due to significant and abiding inequities in the current health system, HHB was failing to reach Māori who most need to access primary care services. This is now changing, with HHB recognising that the make-up and cultural paradigm of Māori whānau, hapū (extended whānau network) and iwi (tribal affiliation) are different systems to those currently being used in our health system. HHB then acknowledged there was a network in place based on whānau and whānaungatanga (system of relational connectedness), and became willing to ask questions rather than focus on fixing problems. The question '*what can we do to help you do what you need to do?*' reflects HHB's aim to work with the existing community strengths to influence and build whānau resilience, and support the community to 'own' and sustain the activities initiated by HHB. In 2012, HHB embarked on a journey with Waimarama Marae, which is situated 30 kilometres from the closest urban area. Waimarama Marae was in the process of taking ownership and accountability of their health and wellbeing when it first engaged with HHB. The Marae aspirations were to have a nurse clinic, transport to access general practice particularly for the Kaumātua (older people) and more health support from the health clinic sited at the Marae. HHB supported the introduction of the Stanford University Chronic Disease Self-Management Programme (Better Choices, Better Health® Workshop). The Marae health champion and a community member have been trained to deliver this programme, which has resulted in 9 Marae whānau graduating from the first programme with the potential to impact positive effects to a further 72 individuals; these 9 are now equipped to manage their own health and wellbeing better and are actively engaging their whānau in discussions about health and wellbeing. A further 12 from connected Marae in the area are requesting to be trained as lay trainers. As a result of the local community telling others about this programme, other providers and general practice have begun to ask for training. HHB emphasises that a key lesson was to work with the natural rhythms of the community and to take time to know the community aspiration. The key for this community was being on their Tūrangawaewae (a place to stand and be listened to and heard) supported by people from their own community.

**Comment:** A great reference for people who want to understand 'whānau ora' in action. Ehara tōku toa i te toa takitahi. He toa takitini tōku toa. *My heroism is not individual, it is collective.*

Reference: *Int J Integr Care. 2015;15(WCIC Conf Suppl)*

[Abstract](#)

## Racial discrimination and ethnic disparities in sleep disturbance: the 2002/03 New Zealand Health Survey

Authors: Paine SJ et al.

**Summary:** This analysis examined the relationship between ethnicity, sex, age, socioeconomic position, experience of racial discrimination and self-reported sleep disturbances in a cohort of 4108 Māori and 6261 Europeans aged ≥15 years who participated in the 2002/03 New Zealand Health Survey. Experiences of racial discrimination across 5 domains were used to assess overall racial discrimination 'ever' and the level of exposure to racial discrimination. Socioeconomic position was measured using neighbourhood deprivation, education, and equivalised household income. For each sleep disturbance item (difficulty falling asleep, frequent nocturnal awakenings, early morning awakenings), prevalence rates were higher among Māori than among Europeans. In analyses adjusted for ethnicity, sex, age group, and socioeconomic position, reported experiences of racial discrimination were independently associated with each sleep disturbance item. In logistic regression analyses, racial discrimination and socioeconomic position explained most of the disparity in difficulty falling asleep and frequent nocturnal awakening between Māori and Europeans; ethnic differences remained in early morning awakenings.

**Comment:** A really interesting paper that has me thinking more about the complex pathway between racism and poor sleep, and the wider effects on health including hypertension, cardiovascular disease and diabetes.

Reference: *Sleep. 2015 Oct 5. [Epub ahead of print]*

[Abstract](#)



Time spent reading this publication has been approved for CME for Royal New Zealand College of General Practitioners (RNZCGP) General Practice Educational Programme Stage 2 (GPEP2) and the Maintenance of Professional Standards (MOPS) purposes, provided that a Learning Reflection Form is completed. Please [CLICK HERE](#) to download your CPD MOPS Learning Reflection Form. One form per review read would be required.



Time spent reading this publication has been approved for CNE by The College of Nurses Aotearoa (NZ) for RNs and NPs. For more information on how to claim CNE hours please [CLICK HERE](#)

### 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 Rangiuira and Waimarie.



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## Neoliberalism and indigenous knowledge: Māori health research and the cultural politics of New Zealand's "National Science Challenges"

**Authors:** Prussing E, Newbury E

**Summary:** New Zealand's Ministry of Business, Innovation and Employment (MBIE) rapidly implemented a major restructuring of national scientific research funding in 2012–13. The "National Science Challenges" (NSC) initiative aims to promote greater commercial applications of scientific knowledge, reflecting ongoing neoliberal reforms in New Zealand. These researchers analysed the texts of MBIE documents about the NSC from 2012–14, materials circulated by Māori researchers in the blogosphere in 2014, and data from ethnographic interviews conducted in 2013 with 17 Māori health researchers working in university-based research centers, government agencies, or independent consultancies. Through 2013, NSC rhetoric and practice moved to marginalise participation by Māori researchers, in part through constructing "Māori" and "science" as essentially separate arenas – yet at the same time the NSC appeared to recognise and value culturally distinctive forms of Māori knowledge. Māori health researchers contested this "neoliberal multiculturalism" by reasserting the validity of culturally distinctive knowledge, strategically appropriated NSC rhetoric, and marshalled political resources to protect Māori research infrastructure. The paper holds that by foregrounding scientific knowledge production as an arena of contestation over neoliberal values and priorities and scrutinising how neoliberalising tactics can include moves to acknowledge cultural diversity, new questions arise for social scientific study of global trends toward reconfiguring the production of knowledge about health.

**Comment:** The authors travelled to Aotearoa and interviewed a number of kaupapa Māori researchers, including me, for this study. Those of us involved in the NSC continue to experience the tensions of wanting to make a positive contribution to Māori knowledge/environment/health through excellent research, aware that we are working within a paradigm that doesn't feel ours.

**Reference:** *Soc Sci Med.* 2016;150:57-66

[Abstract](#)

## Environmental determinants of childhood obesity: a specific focus on Māori and Pasifika in New Zealand

**Authors:** Stoner L et al.

**Summary:** Māori and Pacific children comprise a relatively small proportion of the total New Zealand population, but are disproportionately burdened by obesity. Despite an escalating obesity burden in this country, there is a lack of investment in prevention strategies that take into account the multidimensional, complex interactions between individual and lifestyle behaviours. The article argues for the importance of public health policy that is underpinned by knowledge of the behaviour of complex systems and the recognition that population trends such as obesity emerge because of systemic interactions. For instance, active transport to school, to promote physical activity, may negatively impact nutritional behaviour if the food environment on the journey to school is obesogenic. The article goes on to point out that while the food environment is influenced by a community's ability to advocate for regulation, political participation is constrained by both material deprivation and the influence of racism. It concludes that obesity prevention aimed at children has to enable and empower families/whānau and communities to make healthy decisions and must address/redress political and power relationships that shape the material and social environments where children live.

**Comment:** A fantastic paper that clearly explains the process in which historical and institutionalised racism leads to the obesogenic environments in which our communities live. Excuse the pun but really good food for thought.

**Reference:** *Perspect Public Health.* 2016;136(1):18-20

[Abstract](#)

## The percentage of women who were offered the Levonorgestrel Intrauterine System for heavy menstrual bleeding prior to hysterectomy: clinical audit

**Authors:** Matthews C, Stevenson S

**Summary:** This clinical audit investigated how many women with heavy menstrual bleeding were offered a levonorgestrel intrauterine system (LNG-IUS) prior to hysterectomy at Middlemore Hospital in South Auckland, over a 12-month period (from 30 April 2014 to 1 May 2015). Of the 81 patients who met the study inclusion criteria, 63 (78%) were offered and 18 (22%) were not offered the LNG-IUS before proceeding to a hysterectomy. Of the 63 patients who were offered the LNG-IUS, 11 (18%) refused the treatment.

**Comment:** Evidence from the US suggests that ethnic disparities occur between African Americans and Whites for all surgical procedures except hysterectomy – where rates are significantly higher for African Americans than other ethnicities. I've often wondered if this was true for Māori women also. This study goes some way to answer the question. It is an audit, and therefore does not have power to show statically significant difference by ethnicity. However, as an audit is meant to be an exercise for improving 'quality of care', you have to wonder if Māori and Asian women (of whom only 75% and 60% were offered gold standard treatment) are receiving 'lesser' quality than NZE women (of whom more than 80% were offered it).

**Reference:** *Pac J Reprod Health.* 2015;1(2):91-4

[Abstract](#)

## Does evidence influence policy

**Authors:** Doran C et al.

**Summary:** The Indigenous Burden of Disease (IBoD) is a comprehensive report of Indigenous disease burden in Australia. These researchers evaluated its potential influence on Australian Indigenous health policy, service expenditure and research funding. A text search of 111 relevant Government and National Health and Medical Research Council (NHMRC) policy documents revealed 22 citations to the IBoD. Immediately after the IBoD was published, Australian governments increased Indigenous health spending, notably for community health and public health. Expenditures also increased on Indigenous hospital separations for chronic diseases. While these changes are broadly consistent with IBoD findings on the significance of chronic disease and policy implications, there is no evidence to suggest that the changes were causally connected to the IBoD. Moreover, changes in NHMRC Indigenous research funding showed little consistency with IBoD's findings.

**Comment:** Always interesting to know whether the evidence we gather, the reports and papers we publish, make a difference to hauora Māori funding and policy, but ultimately, outcomes.

**Reference:** *Aust Health Rev.* 5 Jan 2016. [Epub ahead of print]

[Abstract](#)

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