ISSN 1178-6191

Māori Health Review™

Making Education Easy

Issue 46 – 2013

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Tēnā koutou katoa

Nau mai ki tenei Tirohanga hou Hauora Māori. He rangahau tuhi hou e paa ana ki nga hau ora a ki te oratanga o te Māori. No reira noho ora mai raa i o koutou waahi noho a waahi mahi hoki. Ngā mihi o te wā me te Tau Hou ki a koutou katoa. Noho ora mai.

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

Medical students' and clinical teachers' perceptions of Māori health teaching

Authors: Jones RG et al.

Summary: This qualitative research paper presents the views of medical students early in their clinical training and their clinical teachers with respect to Māori health teaching and learning. The 276 students and 135 clinical teachers were asked to respond to a set of questions about the teaching and assessment of Hauora Māori (Māori health). The content analysis determined that the majority of students question the quality of Hauora Māori teaching and assessment. It also indicated that many clinical teachers felt underprepared to teach this aspect of the curriculum. The study authors discovered a range of views, often polarised, and a degree of resistance to Māori health teaching and learning.

Comment: I found the whole issue of 'hidden curriculum', and its influence on how Hauora Māori is taught at medical schools, most interesting. It is defined here as 'a tendency for only those areas of the curriculum which align with the institution's dominant tacit values to be considered important'. Importantly, it is considered detrimental to the student, in that it leads to conflict about the proper way to fulfill responsibilities – in this case, achieving Hauora Māori outcomes.

Reference: N Z Med J 2013;126(1377):41-50

http://journal.nzma.org.nz/journal/abstract.php?id=5704

CCID Report(s)

The Distribution of Household Crowding in New Zealand: An analysis based on 1991 to 2006 Census data provides evidence that the relative risk of developing CCIDs is higher for Māori and Pacific who are also more likely to be exposed to higher rates of household crowding.

Infectious Diseases Attributable to Household Crowding in New Zealand: A Systematic Review and Burden of Disease Estimate is a systematic review and meta-analysis exploring the relationship between household crowding and ten CCIDs.

Links to both reports funded by the Ministry of Health are available on the University of Otago website at http://www.healthyhousing.org.nz/

For more information, please go to http://www.maorihealth.govt.nz

Impact of pneumococcal vaccine on hospital admission with lower respiratory infection in children resident in South Auckland, New Zealand

Authors: Vogel AM et al.

Summary: These researchers analysed admission rates to any New Zealand hospital from August 2001 through July 2011 for all lower respiratory infection (LRI) including pneumonia for children aged <2 years resident in Counties Manukau District Health Board (CMDHB), to determine the impact of the pneumococcal conjugate vaccine 7 valent (PCV7), introduced in June 2008. There was a gradual decline over time in rates of pneumonia admissions (incidence risk ratio [IRR] for a change of 1 year 0.96; p<0.0001) and of an additional step down in rates of pneumonia admissions after vaccine introduction (IRR pre- to post-PCV 1.51; p<0.0001). There was evidence of a significant decline in pneumonia admissions post-PCV introduction for Pacific children (IRR 1.70; p<0.0001) and other ethnicities (IRR 1.93; p=0.003), but not for Māori children (IRR 1.05; p=0.76). No such evidence of a general change over time or change from pre- to post-vaccine introduction could be demonstrated for bronchiolitis. Māori and Pacific children are at increased risk of admission with LRI compared to European children (relative risk [RR] 4.6 and 5.0, respectively) as are those living in Decile 9 or 10 regions compared with those from other deciles (RR 1.43).

Comment: There are a number of things to highlight in this paper – the importance of monitoring outcomes by ethnicity after introducing an intervention (this study showing that Māori did not receive as great a benefit as non-Māori children from the vaccine); that ethnic disparities in respiratory infection admissions are 4–5 times higher for Māori and Pacifica children in South Auckland; and that ongoing effort to address the wider health determinants, such as poverty, is required.

Reference: N Z Med J 2013;126(1378):26-35

http://journal.nzma.org.nz/journal/abstract.php?id=5743

Cross-sectional study on prevalence, causes and avoidable causes of visual impairment in Māori children

Authors: Chong C, Dai S

Summary: Data were retrospectively analysed from 106 blind and 64 low-vision Māori children (<16 years) enrolled with the Blind and Low Vision Education Network New Zealand (BLENNZ). The leading causes of blindness in Māori children are cerebral visual impairment (41.0%), optic nerve atrophy (19.0%) and optic nerve hypoplasia (13.0%). Avoidable causes of blindness for Māori children amounts to 28.5% of Māori childhood blindness; non-accidental injury (NAI) is the leading cause of blindness in Māori children.

Comment: This project is framed within "The Right to Sight" programme, a global initiative of WHO and the International Agency for the Prevention of Blindness, established with an aim to eliminate avoidable childhood blindness by the year 2020. As the authors say, strategies to address NAI as an 'avoidable cause' for blindness and low vision will be multi-faceted. The authors also highlight the need to address perinatal care, given the fact that for the majority of Māori children with blindness/low vision, its onset is at birth.

Reference: N Z Med J 2013;126(1379):31-8

http://journal.nzma.org.nz/journal/abstract.php?id=5762

SUDI prevention: a review of Māori safe sleep innovations for infants

Authors: Abel S, Tipene-Leach D

Summary: Recent research and policy around sudden unexpected death in infancy (SUDI) have highlighted the importance of SUDI prevention strategies focusing on safe sleep messages, particularly among Māori, who feature prominently in SUDI rates (e.g., between 2002 and 2009 the Māori death rate from suffocation in the place of sleep was 8.22 times the European rate). This paper reviews Māori-initiated innovations for safer infant sleep environments. The development of the wahakura (a flax bassinet modelled on a traditional Māori infant sleeping item) in Gisborne in 2006 proved highly acceptable with Māori and also effective as an infant health promotion vehicle. Since then, the making of wahakura has been promoted by the Māori SIDS Prevention Programme (now known as Whakawhetu) and regional wahakura projects have been developed in Northland, Auckland and the Waikato. The less expensive pēpi-pod portable beds are also proving to be highly acceptable, with an evaluation of their use among primarily Māori and Pacific families reporting that many mothers appreciated being able to confidently have their baby close by, in or on the parental bed. Research is currently being undertaken to provide robust evidence for the safety of these infant sleeping devices, as is the exploration of similar alternatives. The paper's authors suggest that utilising and adapting indigenous infant sleeping methods may also prove appropriate in other countries where SIDS/SUDI persists in indigenous and other marginalised communities.

Comment: A great update on the mahi being undertaken in this important area. Bedsharing has both a historical but also a contemporary (for example, housing and working mums) aspect to it. However, there is increasing evidence that bedsharing puts our babies at risk. We need robust kaupapa Māori research to help parents make good choices.

Reference: N Z Med J 2013;126(1379):86-94

http://journal.nzma.org.nz/journal/abstract.php?id=5764

Injury severity and 3-month outcomes among Māori: results from a New Zealand prospective cohort study

Authors: Maclennan B et al.

Summary: Interviews were conducted at 3 months post-injury with 2856 New Zealand residents aged 18–64 years enrolled in the Prospective Outcomes of Injury Study (POIS); all study participants had experienced ≥1 injuries between June 2007 and May 2009. This investigation examined the prevalence of health and social outcomes pre- and 3 months post-injury, and the association between New Injury Severity Scores (NISS) and 3-month outcomes, for the 566 participants who reported Māori ethnicity. High levels of adverse outcomes were observed 3 months post-injury: 49% reported problems with mobility; 56% reported trouble performing usual activities; 70% were experiencing pain or discomfort; and 45% were experiencing a moderate level of psychological distress. The prevalence of some adverse outcomes increased with increasing NISS but a high level of problems were still experienced by those classified as having a 'minor' injury. Nonetheless, 71% were satisfied with life and 81% were satisfied with global social relationships at 3 months, and 74% considered themselves to have good to excellent overall health.

Comment: See below.

Reference: N Z Med J 2013;126(1379):39-49

http://journal.nzma.org.nz/journal/abstract.php?id=5760

Indigenous injury outcomes: life satisfaction among injured Māori in New Zealand three months after injury

Authors: Wyeth E et al.

Summary: This paper describes pre-injury and injury-related predictors of life satisfaction 3 months after injury for 563 of the 566 Māori participants in the POIS. The Te Whare Tapa Whā model of overall health and well-being was used to help inform the selection of post-injury life satisfaction predictor variables. Ninety-three percent of participants reported satisfaction with life pre-injury; 71% were satisfied with life at 3 months post-injury. In multivariate analysis for life satisfaction 3 months after injury, participants with an injury severity NISS >6 were less likely to be satisfied with life 3 months after injury compared with those with injury severities of NISS 1–3 (RR 0.80). In addition, those who were not satisfied with pre-injury social relationships or had poor general self-efficacy pre-injury were less likely to be satisfied with life 3 months after injury.

Comment: Two excellent papers examining the prevalence, outcomes, and predictors of outcomes injuries for Māori.

Reference: Health Qual Life Outcomes 2013;11:120

http://www.hqlo.com/content/11/1/120

Registered nurse assessment and treatment of skin sepsis in New Zealand schools: the development of protocols

Authors: Vogel A et al.

Summary: This paper describes the development of evidence-based protocols for the recognition and treatment of skin sepsis in nurse (RN)-led school clinics in South Auckland, including provision of antibiotics under delegated standing orders. An algorithm for diagnosis of skin infections was adapted from Steer et al. (Bull World Health Organ. 2009;87:173-9). The targeted skin infections include impetigo, cellulitis, scabies and infected eczema. The algorithim recommends fusidic acid ointment as first-line treatment for localised impetigo and twice-daily oral cephalexin for extensive impetigo and cellulitis, for palatability and simplicity of dosing. In the first 15 weeks of a pilot study, 56 school students diagnosed with one or more skin infections were treated under standing orders.

Comment: As the authors say, this protocol will be rolled out and evaluated as part of RN-led school health clinics targeting sore throats and skin infections in 53 schools in the CMDHB region in conjunction with rheumatic fever prevention initiatives.

Reference: N Z Med J 2013;126(1380):15-26

http://journal.nzma.org.nz/journal/abstract.php?id=5780

Māori Health Review

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.

Time trends, ethnicity and risk factors for eczema in New Zealand children: ISAAC Phase Three

Authors: Clayton T et al.

Summary: Outcomes are reported from the 5 New Zealand centres that participated in Phase One (1993) and Phase Three (2001–2003) of the International Study of Asthma and Allergies in Childhood (ISAAC). The first phase found a high prevalence of symptoms of eczema in New Zealand and Phase Three sought to determine whether the prevalence of eczema was changing over time, whether prevalence differs by ethnicity, and to clarify the risk factors for eczema. Whereas there was little change in prevalence over time for the children (6–7-year-olds), eczema decreased in prevalence among the adolescents (13–14-year-olds). Prevalence was higher among Māori and even higher among Pacific participants than among European children. In both age groups, current eczema symptoms were positively associated with truck traffic in the street of residence and with current paracetamol consumption, while for children only, a positive association was seen between current eczema and antibiotics or paracetamol in the 1st year of life. Residence in New Zealand for <5 years, consumption of milk, seafood and eggs, and presence of a dog in the home, were all inversely associated with current eczema.

Comment: As someone recently consulted by the council about an application from a local business to increase truck traffic on the neighbourhood roads, it was useful to have this paper and attach it to my response.

Reference: Asia Pac Allergy 2013;3(3):161-78

http://apallergy.org/DOIx.php?id=10.5415/apallergy.2013.3.3.161

The influence of ethnicity and gender on caregiver health in older New Zealanders

Authors: Alpass F et al.

Summary: Responses were analysed from a representative sample of participants (n=2,155) aged 54–70 years from the first 2 waves of the New Zealand Health, Work and Retirement study who completed postal surveys in 2006 and 2008. These researchers examined the interrelationships between ethnicity, gender, and caregiving on the health of older New Zealanders. Women and Māori were more likely to provide care than men and non-Māori. Poorer mental health was reported by respondents providing higher levels of care; this was particularly true of Māori and female caregivers. Male Māori caregivers providing the highest level of care reported the poorest mental health. Level of care did not relate to physical health. Scant evidence was available to validate changes in health over time based on caregiver status.

Comment: Caregivers report their experience as both being a privilege but also a burden; the latter described in terms of its impact on health, finances, relationships and social activity. The point is that services must recognize, and provide care that is tailored to, the specific needs of Māori caregivers.

Reference: J Gerontol B Psychol Sci Soc Sci 2013;68(5):783-93

http://psychsocgerontology.oxfordjournals.org/content/68/5/783.abstract

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Ethnic disparities in asthma treatment and outcomes in children aged under 15 years in New Zealand: analysis of national databases

Authors: Gillies TD et al.

Summary: Using data from the national pharmaceutical claims database, these researchers identified 80,514 children aged <15 years dispensed >2 asthma medicines, in this investigation into the recommended treatment and outcomes for asthma in all New Zealand children by age, sex, and ethnic group. A total of 16.0% of children were dispensed asthma medicines, 9.2% were dispensed medicine >2 times, 3.6% were hospitalised at least once for asthma and 98.9% of admissions were acute. Māori (OR 1.46) and Pacific children (OR 2.38) were less likely to have their treatment escalated to a higher step than other children. At all steps of treatment, Māori and Pacific children were more likely to be using oral steroids to control asthma exacerbations and in all age groups, Māori children (5.1%; OR 1.88) and Pacific children (5.6%; OR 2.05) were more likely to be hospitalised for asthma than children of other ethnicities (2.8%).

Comment: Research showing ethnic differences in asthma treatment was published in the 1980s by Professor Ed Mitchell and others, and reviewed again in the 1990s and early 2000s by Dr Sue Crengle. It is therefore extremely disheartening to see that asthma burden continues to fall heaviest on Māori children. I would like to acknowledge here too the recent passing of Wiremu Ngatiranginui Tukaokao Rawiri, the son of a good childhood friend of mine. Moe mai e tama.

Reference: Prim Care Respir J 2013;22(3):312-8

http://www.thepcrj.org/journ/view_article.php?article_id=1051