

Māori Health Review™



Making Education Easy

Issue 55 – 2015

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Abbreviations used in this issue

COPD = chronic obstructive pulmonary disease
SUDI = sudden unexpected death in infancy

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Māori Health Review

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 mahana 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

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Infant care practices related to sudden unexpected death in infancy: a 2013 survey

Authors: Hutchinson BL et al.

Summary: Outcomes are reported from a postal questionnaire sent out in August 2013 to 400 randomly selected mothers of infants aged between 6 weeks and 4 months who had been delivered at Auckland National Women's Health. The survey sought to determine mothers' knowledge of, and practices related to, risk factors for sudden unexpected death in infancy (SUDI) and to compare results with a similar survey conducted in 2005. Questions asked about sleep position, bed sharing, room sharing, smoking, and breastfeeding. Completed questionnaires were obtained from 172 (43%) women. As in the 2005 survey, European mothers were more likely to respond than Maori, Pacific, and Other mothers. Other ethnicities comprised predominantly Asian ethnicities. Compared with 2005, more women in this survey cited avoiding bed sharing, keeping the face clear, avoiding soft bedding, and room sharing as SUDI prevention factors. Compared with 2005, significantly more mothers in this survey cited advice to avoid bed sharing, keep the face clear, use a firm sleep surface, avoid soft bedding, and sleep in the same room as the parent. Fewer mothers reported smoking during pregnancy or around baby (69% vs 73% in 2005) and fewer infants usually shared a bed for some or all of the night (8% vs 15% in 2005). Of the five main protective factors promoted by New Zealand's Ministry of Health (supine sleep, own bed, room sharing, smoke free, breastfeeding), 43% were implementing all of these practices. Those who did so were significantly more likely to be mothers of firstborn infants ($p=0.01$).

Comment: The sustained efforts of many must be applauded when looking at these fantastic results. I also look forward to seeing further reductions in SUDI rates, and inequities, with the mahi undertaken by Whakawhetu and the research into pepi pods. For more information about Whakawhetu see their website <http://www.whakawhetu.co.nz/>.

Reference: *N Z Med J. 2015;128(1408):15-22*

[Abstract](#)

FINDINGS FROM STUDY ABOUT PEOPLE IN ADVANCED AGE NOW AVAILABLE

Life and Living in Advanced Age: a cohort study in New Zealand (LiLACS NZ) is a longitudinal study of Māori (aged 80 to 90 years) and non-Māori (aged 85 years) living in the Bay of Plenty. A series of short reports presenting findings from year one of the study is now available. Short reports about Alcohol use, Falls, Medication use and perceptions of GP care, Hospital visits, and Income are available along with the Oral health short report released last year. The reports were funded by the Ministry of Health and produced by the LiLACS NZ research programme which is led by Professor Ngaire Kerse.

LILACS NZ



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Hospital admissions for chronic obstructive pulmonary disease in New Zealand

Authors: Milne RJ, Beasley R

Summary: National hospital admissions were analysed for chronic obstructive pulmonary disease (COPD) in New Zealand over a 5-year period, to estimate the 5-year trends and distribution by age, prioritised ethnicity, socio-economic status, length of stay and district health board (DHB). The investigation also sought to determine the impact of these admissions on the public healthcare budget. National patient-level routine data on admissions with a principal clinical diagnosis of COPD (mostly ICD-10 codes J440 and J441) were obtained for the period 1 July 2008 to 30 June 2013. There 61,516 hospital admissions including day stays over the study period. The annual admission rate was stable across the 5-year period, with a budget impact in financial years (FY)2012/13 dollar values of \$59.62m, but the average length of stay (ALOS) declined from 5.09 to 4.37 days. In FY2012/13 the admission rate was 2.82 per 1000 population; age-standardised admission rates (ASR) were 4.4-fold higher for Māori and 3.6-fold higher for Pacific peoples than for European/other ethnicities. For individuals aged ≥ 15 years, the ASR was 2.55 per 1000. Admission rates were higher for men than women and increased steeply with age and socioeconomic deprivation (NZDep06). The mean age at discharge was lower for Māori and Pacific peoples than for European/Others (63.4, 67.1 and 72.3 years). The mean 30-day readmission rate was 6.7%. The ALOS increased with age and was shorter for Māori (3.59 days) and Pacific peoples (3.48 days) than for European/Others (4.65 days). Admission rates varied widely across DHBs, and were higher in rural than urban regions. The ALOS (including day stays) also differed considerably across DHBs, ranging from 3.52 to 6.12.

Comment: A great review of COPD admissions across NZ that should inform appropriate interventions. I particularly found the data showing shorter 'length of stay' despite higher admission rates for Māori concerning.

Reference: *N Z Med J. 2015;128(1408):23-35*

[Abstract](#)

Epidemiology, disease burden and outcomes of cirrhosis in a large secondary care hospital in South Auckland, New Zealand

Authors: Hsiang JC et al.

Summary: In this study, cirrhosis complications and mortality data were retrospectively analysed from 746 cirrhosis patients under secondary public hospital care in South Auckland, between the years 2000 and 2011. Ethnicities were mostly European/Other (39.9%), Pacific islanders (21.6%), Southeast Asian/Chinese (17.8%) and Maori (12.3%). 68.4% of the cohort were male. The common primary aetiologies for cirrhosis were chronic hepatitis B (CHB) cirrhosis (37.3%), alcoholic liver disease (ALD) cirrhosis (24.1%), chronic hepatitis C (CHC) cirrhosis (22.3%) and non-alcoholic fatty liver disease (NAFLD) cirrhosis (16.4%). The hepatocellular carcinoma (HCC) mortality rates were highest in NAFLD and CHB cirrhosis groups (3.0 and 3.1 per 100 patient-years, respectively), compared with ALD and CHC groups (2.2 and 1.4 per 100 patient-years; $p < 0.05$ for all comparisons). Higher rates of all-cause and non-HCC mortality were observed among patients with ALD and NAFLD cirrhosis compared with viral hepatitis cirrhosis cohorts. Incidence rate ratios (IRR) for HCC incidence, liver-related mortality and HCC mortality were 1.087, 1.098 and 1.114, respectively (all $p < 0.001$), suggesting increasing incidence and disease burden over the study period.

Comment: For me, this study highlights the fact that hepatitis B and C, as well as non-alcoholic fatty liver disease, are major causes for cirrhosis and liver cancer in Aotearoa. The discourse about higher rates of liver disease in indigenous people – from clinicians and communities – focuses on alcohol. These results suggest more can be done to prevent and manage infectious and non-communicable (such as diabetes) risk factors.

Reference: *Intern Med J. 2015;45(2):160-9*

[Abstract](#)



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Disclaimer: This publication is not intended as a replacement for regular medical education but to assist in the process. The reviews are a summarised interpretation of the published study and reflect the opinion of the writer rather than those of the research group or scientific journal. It is suggested readers review the full trial data before forming a final conclusion on its merits.

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After the RCT: who comes to a family-based intervention for childhood overweight or obesity when it is implemented at scale in the community?

Authors: Fagg J et al.

Summary: The UK-based MEND 7–13 (Mind, Exercise, Nutrition Do it!) programme is a multicomponent family-based weight management intervention for childhood overweight and obesity implemented at scale in the community. The intervention was demonstrated to be effective in reducing body mass index (BMI) of obese children after 6 and 12 months in a randomised controlled trial. Between 2007 and 2010, the MEND intervention was implemented on a large scale, with programmes rolled out across all regions of England. These researchers explored whether the sociodemographic characteristics of MEND participants match those of the population eligible for the intervention, and they examined what predicts completion of a MEND programme. The study cohort included 18,289 children referred to 1940 MEND programmes. Compared to the MEND-eligible population, proportionally more MEND starters were: obese rather than overweight but not obese; girls; Asian; from families with a lone parent; living in less favourable socioeconomic circumstances; and living in urban rather than rural or suburban areas. Children who had started the programme were significantly less likely to complete it if they: were reported by parents as having 'abnormal' rather than 'normal' levels of psychological distress; were boys; were from lone parent rather than couple parent families; lived in less favourable socioeconomic circumstances; and had participated in a relatively large MEND programme group; or where managers had run more programmes.

Comment: An excellent example of how to evaluate a public health intervention. Whilst the RCT may have shown that it was effective, and they have had good uptake in the beginning, 'real life' comes into the mix.

Reference: *J Epidemiol Community Health.* 2015;69(2):142-8

[Abstract](#)

Indigenous child health: Are we making progress?

Authors: Brewster DR, Morris PS

Summary: These researchers searched all articles published in the *Australian Paediatric Journal* (1965–1989) and *Journal of Paediatrics and Child Health* (1990–2014) and identified 244 that were directly relevant to Indigenous child health (4% of the total) with a steady increase in number since 1995. Publications in the journal are largely descriptive studies with relatively few systematic reviews and randomised trials. This review attempts to cover the important Indigenous health issues in Australia and New Zealand as represented by the published articles. The earliest studies documented the poor state of health of Indigenous children in Northern Australia, particularly in terms of growth delays, high burden of infectious diseases and high prevalence of rheumatic heart disease. Studies in the 1990s documented high rates of environmental enteropathy, parasitic diarrhoea, failure-to-thrive, and chronic lung and ear infections. Most Australian publications in the journal (with a small Indigenous population) have focused on conditions and settings where nearly all (affected) children are Indigenous. In contrast, New Zealand publications (with a large Māori and Pacific Islander population) have addressed important health issues affecting all children but emphasised the over-representation of Māori and Pacific Islanders. The studies reflect improvements in Indigenous child health over the last 50 years. The current focus is on improving the social determinants of health, such as educational levels, housing and hygiene.

Comment: An interesting examination of the way in which Indigenous health is presented/represented in medical journals. Interestingly, the authors highlight the fact that the focus has shifted from describing higher rates of disease to more recently defining the wider determinants that cause/maintain health disparities.

Reference: *J Paediatr Child Health.* 2015;51(1):40-7

[Abstract](#)

Impact of mammographic screening on ethnic and socioeconomic inequities in breast cancer stage at diagnosis and survival in New Zealand: a cohort study

Authors: Seneviratne S et al.

Summary: This study explored differences in rates of screen-detected breast cancer by ethnicity and socioeconomic deprivation in a cohort of screening age women, and sought to determine the contribution of these differences to ethnic and socioeconomic inequities in breast cancer survival among Māori and New Zealand European women. Records from the Waikato Breast Cancer Register and the National Screening Database identified all screening age women with newly diagnosed breast cancer (50–64 years up to June 2004 and 45–69 years from July 2005 onwards, as defined by the New Zealand National Breast Cancer Screening Programme) between 1 January 1999 and 31 December 2012 in the Waikato area. Stage at diagnosis and survival were compared for screen-detected (n=1106) and non-screen-detected (n=740) breast cancer by ethnicity and socioeconomic status. Indigenous Māori women were significantly more likely to be diagnosed with more advanced cancer compared with New Zealand European women (OR1.51) and approximately a half of this difference was explained by lower rate of screen-detected cancer for Māori women. For non-screen-detected cancer, Māori had significantly lower 10-year breast cancer survival compared with New Zealand Europeans (46.5% vs 73.2%) as did most deprived compared with most affluent socioeconomic quintiles (64.8% vs 81.1%). No significant survival differences were observed for screen-detected cancer by ethnicity or socioeconomic deprivation.

Comment: A key piece of research showing the importance of achieving equity in cancer screening programmes.

Reference: *BMC Public Health.* 2015;15:46

[Abstract](#)

PERFORMANCE OF GENERAL PRACTICES IN WHĀNAU ORA COLLECTIVES

REPORT FOR THE PERIOD ENDING SEPTEMBER 2014

The latest report regarding the performance of general practices in Whānau Ora collectives is available on the www.health.govt.nz website.

General practices within Whānau Ora collectives continue to outperform practices within the national sample on several key areas. The report highlights further increases in several key indicators including: review of diabetes patients, flu vaccinations for older people (65+ years), and mean fee charged for enrolled patients.

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THE FULL REPORT CAN BE FOUND [HERE](#)

Managing communication tensions and challenges during the end-of-life journey: perspectives of Māori kaumātua and their whānau

Authors: Oetzel J et al.

Summary: Using relational dialectics theory, these researchers explored the cultural practices and communication tensions arising among Māori kaumātua (elders) and their whānau (extended family) during the end-of-life journey. Interviews were conducted with 21 kaumātua and focus groups with 39 whānau members. The study identified three cultural practices (dying at home, prayer, and song) that helped to build connection among the family members and also helped to connect the dying person to the spiritual world. Four communication tensions were identified: (a) autonomy and connection; (b) conflict and connection; (c) isolation and connection; and (d) balancing the needs of self and other. The following strategies were used to manage these tensions: (a) coordination conversations; (b) inclusion in decision-making conversations; (c) emotional support within the whānau; and (d) passing on lessons to the next generation.

Comment: There has been a lot of great work undertaken recently on end-of-life and palliative care experiences for Māori and their whānau. This research focuses on the challenges in communication we face during this time, and takes a strength-based approach in presenting the ways in which we meet and address these.

Reference: *Health Commun.* 2015;30(4):350-60

[Abstract](#)

The politics of relative deprivation: A transdisciplinary social justice perspective

Authors: Fu M et al.

Summary: This paper presents a critical analysis of relative deprivation as defined by Townsend (1987, p.125: “a state of observable and demonstrable disadvantage, relative to the local community or the wider society or nation to which an individual, family or group belongs”), which has been widely applied throughout social and health sciences to identify, measure, and explain forms of inequality in human societies based on material and social conditions. Based on a perspective grounded in Aotearoa/New Zealand, where colonisation has shaped the contours of racialised health inequities and current applications and understandings of ‘deprivation’, these researchers suggest alternatives to Townsend’s concept of deprivation that work better towards social justice. They argue that using deprivation measures without critical reflection can result in deficit framing of populations and maintain current inequities in health and social outcomes. Further, they contend that a central concern in studies of deprivation is their lack of consideration of (bio)power, privilege, epistemology and (bio)politics. They challenge the academy to interrogate political economic causes of inequalities and to measure the unequal distribution of power and privilege in populations.

Comment: Many have argued about the use of ‘deprivation’ in health research, and while this paper doesn’t provide the answers, the authors raise some good points here. For example, does it facilitate the examination beyond a person’s level of ‘deprivation’ per se to the larger macro forces in society, such as institutional racism, which influence the differential access to societal resources and opportunities (such as employment, income, education).

Reference: *Soc Sci Med.* 2014 Dec 23. [Epub ahead of print]

[Abstract](#)

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Ethnic discrimination predicts poor self-rated health and cortisol in pregnancy: Insights from New Zealand

Authors: Thayer ZM, Kuzawa CW

Summary: These researchers evaluated the relationship between perceived discrimination, self-rated health, and the stress hormone cortisol measured in late pregnancy among a diverse sample of 55 women living in Auckland, New Zealand. All were recruited from two antenatal care clinics in Auckland. Women were met in their homes between 34 and 36 weeks gestation, and were asked to complete a prenatal stress questionnaire and give saliva samples (morning and evening from two days). Offspring cortisol reactivity was assessed in 19 infants at the standard 6-week postnatal vaccination visit, in order to evaluate possible intergenerational impacts of maternal discrimination on stress reactivity. A total of 34% of women reported having experienced ethnic discrimination. Minority and immigrant women were more likely to report being angry or upset in response to discrimination experience compared with New Zealand-born women of European descent. Maternal discrimination experience was associated with worse self-rated health, higher evening cortisol in late pregnancy and higher cortisol reactivity in offspring, independently of ethnicity and material deprivation.

Comment: I don’t think I could say it any better than the authors when they conclude that “these findings suggest that reducing exposure to ethnic discrimination experience may not only improve health outcomes among exposed individuals, but also in future generations”.

Reference: *Soc Sci Med.* 2015;128:36-42

[Abstract](#)

A tertiary approach to improving equity in health: quantitative analysis of the Māori and Pacific Admission Scheme (MAPAS) process, 2008–2012

Authors: Curtis E et al.

Summary: These researchers used an Indigenous Kaupapa Māori methodology to explore the admission processes of the Māori and Pacific Admission Scheme (MAPAS), a tertiary admission programme that targets Māori and Pacific applicants to nursing, pharmacy and health sciences at the University of Auckland. Data were analysed for the period 2008–2012. Multiple logistic regression models were used to identify the predicted effect of admission variables on the final MAPAS recommendation of best starting point for success in health professional study, i.e., ‘CertHSc’ (Certificate in Health Sciences, bridging/foundation), ‘Bachelor’ (degree-level) or ‘Not FMHS’ (Faculty of Medical and Health Sciences). Of a total of 918 MAPAS interviewees, 319 (35%) were Māori, 530 (58%) Pacific, 68 (7%) Māori/Pacific, 653 (71%) were school leavers, and 662 (72%) were females. The average rank score was 167/320, 40–80 credits below guaranteed FMHS degree offers. Almost half of all interviewees were recommended ‘CertHSc’ as the best starting point (n=428; 47%); 117 (13%) were recommended ‘Bachelor’ and 332 (38%) ‘Not FMHS’. Bachelor recommendation was strongly associated with exposure to Any 2 Sciences (OR 7.897; 95% CI, 3.855 to 16.175; p<0.0001), higher rank score (OR 1.043; 95% CI, 1.034 to 1.052; p<0.0001) and higher scores on the MAPAS mathematics test (OR 1.043; 95% CI, 1.028 to 1.059; p<0.0001). Multiple Mini Interview stations had mixed associations, with academic preparation and career aspirations more consistently associated with recommendations.

Comment: An excellent example of kaupapa Māori research that examines the pathways into and through university-led health programmes for Māori students.

Reference: *Int J Equity Health.* 2015;14:7

[Abstract](#)



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