

# Māori Health Review™



Making Education Easy

Issue 39 - 2012

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### Abbreviations used in this issue

- CT** = computed tomographic  
**CYF** = Child Youth and Family  
**DHB** = District Health Board

## 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. Noho ora mai. Matire.

## 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. It was also great to see many of you at Hui Whakapiripiri - looking forward to seeing you at the next one!

Stay well, regards

### Matire

Dr Matire Harwood

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## Exploring Māori health worker perspectives on colorectal cancer and screening

**Authors:** Pitama S et al

**Summary:** In this pilot study, 30 Māori health workers were interviewed about their experience with screening programmes, knowledge of colorectal cancer and their perspective on a potential colorectal screening programme. This perspective was informed by both their own whānau and whānau they encountered professionally through their health work. While participants were largely positive about potential colorectal screening, various access barriers that they identified included patient-clinician engagement and communication, lack of provision for patient's privacy during screening and patients feeling discouraged to take part in screening. Factors enabling screening included having an established relationship with their General Practitioner, screening clinicians taking time to build rapport, answer questions and share information, screening practices that were inclusive of Māori cultural norms and having high health literacy.

**Comment:** This study has provided valuable information on ways to improve screening programmes for Māori. Interestingly, there have been major concerns about the 'cultural appropriateness' of colorectal screening (i.e. test kits for tiko); yet comments from participants appeared to focus on relationships and service issues.

**Reference:** *N Z Med J.* 2012;125(1356):75-84.

<http://journal.nzma.org.nz/journal/abstract.php?id=5214>

## Foundation Course in Cultural Competency

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## Trends in child and adolescent discharges at a New Zealand psychiatric inpatient unit between 1998 and 2007

**Authors:** van Kessel J et al

**Summary:** These researchers retrospectively analysed sociodemographic and diagnostic data from an acute child and adolescent psychiatric inpatient unit in the North Island between January 1998 and December 2007. Over half of all 1109 discharges (53.4%; n=588) in the 10-year review period involved young people who identified as European, with the remaining sample identifying as NZ Māori (29.1%; n=321), Pacific Islander (7.4%; n=82), Asian (7.1%; n=78), or Other (3.0%; n=33). Māori young people were over-represented in the discharges and Pacific Island young people under-represented compared to the ethnic proportions of the relevant age group of the catchment area of the unit. The number of discharges significantly increased over the 10 years, with 68% more discharges in 2007 compared to 1998, and a linear trend of 8 additional discharges per year. Significant linear trends of increasing proportions of psychotic disorders and decreasing proportions of affective, bipolar affective, personality traits, suicidal/self-harm, and externalising behaviour disorders were observed. There was also a significant decrease in the proportion of discharges of young people of European descent and a significant increase in proportion of discharges of those of Māori descent. There was no significant change in length of stay over time.

**Comment:** Having shown changing trends in the demographic and mental health profiles of young people requiring psychiatric hospitalisation, the key now is to develop appropriate services that meet the needs of clients and their whānau.

**Reference:** *N Z Med J.* 2012;125(1355):55-61.

<http://journal.nzma.org.nz/journal/abstract.php?id=5198>

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## Computed tomographic colonography (CTC): a retrospective analysis of a single site experience and a review of the literature on the status of CTC

**Authors:** Ghuman M et al

**Summary:** Data were retrospectively analysed from 302 patients who underwent CT colonography (CTC) between August 2007 and August 2010 at Greenlane Hospital, the outpatient hospital for Auckland DHB. Twelve patients (4%) were found to have cancer, 24 (8%) had polyps >5 mm, and 111 (37%) had diverticular disease. 21 patients (7%) were referred for optical colonoscopy following their CTC, and 34 patients (11%) had follow-up recommendations resulting from extracolonic findings, including 24 recommendations for further imaging. The majority of the study population was New Zealand European (59%), Asian (17%), or Other Europeans (10%); only 5.1% were Māori and 4.1% Pacific Islander. The study authors recommend that Māori and Pacific Islanders be encouraged by primary health practitioners to present for bowel examination.

**Comment:** Unless the authors can provide evidence of higher 'did not attend' rates for Māori and Pacifica peoples, I'd argue that it's the clinicians who need the encouragement to refer Māori and Pacifica peoples to CTC, rather than encouraging patients to present.

**Reference:** *N Z Med J.* 2012;125(1356):60-7.

<http://journal.nzma.org.nz/journal/abstract.php?id=5218>

## Risk factors for community-acquired pneumonia in pre-school-aged children

**Authors:** Grant CC et al

**Summary:** This paper discusses risk factors for pre-school-aged children developing and being hospitalised with community-acquired pneumonia in New Zealand, using data from a cohort of children aged <5 years old residing in urban Auckland between 2002 and 2004. To assess the risk of developing pneumonia, 289 children hospitalised with pneumonia plus 139 children with pneumonia discharged from the Emergency Department were compared with a random community sample of 351 children without pneumonia. To assess risk of hospitalisation, children hospitalised with pneumonia were compared with those discharged from the Emergency Department. After adjustment for season, age and ethnicity, the risk of pneumonia was higher in children with lower weight for height (OR 1.28), those spending less time outside (1.96), with previous chest infections (2.31) and having mould in the bedroom (1.93). The risk of pneumonia hospitalisation was more likely among children with a maternal history of pneumonia (4.03), living in a more crowded household (2.87) and one with cigarette smokers (1.99), and having mould in the bedroom (2.39).

**Comment:** Further evidence that more must be done to address the wider, particularly environmental, respiratory health determinants in order to eliminate disparities and improve outcomes.

**Reference:** *J Paediatr Child Health.* 2012;48(5):402-12.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1754.2011.02244.x/abstract>

## 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.



Research Review publications are intended for New Zealand health professionals.

## Medical assessment for child sexual abuse: A post-code lottery?

**Authors:** Everitt R et al

**Summary:** These researchers determined that 804 medical assessments for child and adolescent sexual abuse (children aged 0 to 16) were performed over 12 months (July 1 2006 to June 30 2007) throughout NZ. CYF received 73,326 notifications; 46,776 required further action (investigation). Child protective services regarded 1207 cases as substantiated, and 1434 claims for mental injury were lodged. CYF was involved in 628 of the 804 cases seen for medical assessment. In the matched Auckland cohort, CYF substantiated 162 of the 317 cases of sexual abuse in Auckland that year. However, CYF substantiated 418 cases of sexual abuse in Auckland that year. Therefore, only 162/418 (38%) were medically assessed. A doctor with expertise in the assessment of sexual abuse was available in most areas, but service structure varied widely. The availability of nurse or social work support was poor. The proportion of children and adolescents receiving a medical assessment, and the quality of service structure, was directly related to regional population.

**Comment:** Surely this is an area that requires 1. A national, standardised approach and 2. Timely, appropriate and specialised care. Hopefully, this is something that the Children's Commissioner will address or an issue that Owen Glenn's donation will tackle.

**Reference:** *J Paediatr Child Health.* 2012;48(5):389-94.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1754.2011.02222.x/abstract>

## The cost of child health inequalities in Aotearoa New Zealand: a preliminary scoping study

**Authors:** Mills C et al

**Summary:** Findings are reported from a preliminary analysis of the cost of health inequities between Māori and non-Māori children in New Zealand. The estimate of the health sector costs of child health inequities between Māori and non-Māori suggests a cost saving to the health sector of \$24,737,408 per annum. However, significant societal costs were identified: over \$NZ62 million per year in a conservative "base case" scenario estimate, with alternative costing methods identifying even larger costs of nearly \$NZ200 million per annum. The total cost estimate was found to be highly sensitive to the costing method used, the discount rate and Value of Statistical Life applied: the cost of potentially avoidable deaths of Māori children was a large proportion of the total costs.

**Comment:** Although described by the authors as a scoping study, the preliminary findings are astounding. Not only have they shown preferential spending by ethnicity in Aotearoa, but they have also highlighted the fact that traditional methods and measures may underestimate the problem.

**Reference:** *BMC Public Health.* 2012;12(1):384.

<http://www.biomedcentral.com/1471-2458/12/384/abstract>

## The practice of surrogacy in New Zealand

**Authors:** Anderson L et al

**Summary:** The New Zealand Human Assisted Reproductive Technology Act 2004 (HART Act) prohibits commercial surrogacy but does allow for altruistic clinic-assisted surrogacy. Couples wishing to attempt altruistic surrogacy must apply for approval to a statutorily appointed ethics committee. These researchers reviewed the outcomes of surrogacy applications since the HART Act was established and the uptake of surrogacy by Māori. Of 104 applications for surrogacy between 2005 and 2010, 4 (3.8%) were declined. By July 2011, of 100 approved, there were 26 (26%) live births; 52 (52%) were discontinued, and 22 (22%) were ongoing. Māori are much less likely to utilise surrogacy. Of the 104 original applications, 9 (8.6%) Māori women were willing to act as a surrogate, and 2 (1.9%) were intended mothers. Seven (6.7%) Māori were partners of a surrogate, with 2 (1.9%) intending mothers having Māori partners.

**Comment:** I thought this was an interesting paper as I see the adverts calling for potential surrogates and always wonder about the people behind them. Importantly, the study reviewed applications to HART and did not look at non-HART surrogacy. This may be more difficult to estimate and examine.

**Reference:** *Aust N Z J Obstet Gynaecol.* 2012;52(3):253-7.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1479-828X.2012.01419.x/abstract>

## The incidence, clinical features, and treatment of type 2 diabetes in children <15 yr in a population-based cohort from Auckland, New Zealand, 1995–2007

**Authors:** Jefferies C et al

**Summary:** Data were retrospectively analysed from 52 patients with type 2 diabetes mellitus (T2DM) from a population-based treatment referral cohort, from 1 January 1995 to 31 December 2007. Over this time, the annual incidence of new cases of T2DM in children <15 years increased 5-fold in the Auckland region (from 0.5/100,000 in 1995 to 2.5/100,000 in 2007). The average annual incidence per 100,000 over the entire period was 1.3 overall, 0.1 in Europeans, and 3.4 in both Māori and Pacifica. Fifty-seven percent of children were symptomatic at presentation. Fifty-eight percent of patients were treated with insulin from diagnosis, most of whom were symptomatic. Follow-up data were available for 48 patients with a mean of 2.4 yr. Although insulin therapy was associated with a greater fall in HbA<sub>1c</sub> values in the first 12 months of treatment (to a nadir of 7.1 vs 8.1%; p<0.05), there was a rapid deterioration after 12 months, and subsequent mean HbA<sub>1c</sub> values were >9% in both groups.

**Comment:** Major messages here to those working in primary care about type 2 DM in under 15-year-olds – the incidence has increased five-fold in the past decade; children are symptomatic but diagnosis is late; and it is poorly managed. Appropriate investigation is required in suspect cases or we may need to consider some form of screening programme.

**Reference:** *Pediatr Diabetes.* 2012 May 31.

doi: 10.1111/j.1399-5448.2012.00851.x. [Epub ahead of print]

<http://onlinelibrary.wiley.com/doi/10.1111/j.1399-5448.2011.00851.x/abstract>

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## A decade of tobacco control efforts in New Zealand (1996–2006): Impacts on inequalities in census-derived smoking prevalence

**Authors:** Salmond C et al

**Summary:** Between 1996 and 2006, a range of tobacco control activities were implemented in New Zealand. Data from the 1996 and 2006 national censuses were compared in this investigation, which examined the relationships between smoking prevalence and age, sex, socioeconomic position, and ethnicity. Throughout the decade, there was no change in the strong relationship between small-area socioeconomic deprivation and smoking prevalence. Smoking prevalence continued to be associated with Māori ethnicity independently of small-area socioeconomic deprivation. Smoking prevalence reduced modestly between 1996 and 2006 but increased in some age/sex/ethnic/deprivation groups.

**Comment:** Studies like this are required to be able to show whether tobacco control is working, and whether strategies are effective for all/equitably. Given the recent changes in policy, including further increases in tobacco tax, more recent data is required.

**Reference:** *Nicotine Tob Res.* 2012;14(6):664-73.

<http://ntr.oxfordjournals.org/content/14/6/664>

## Geographic, ethnic and socioeconomic factors influencing access to implantable cardioverter defibrillators (ICDs) in New Zealand

**Authors:** Wilson D et al

**Summary:** All new implanted cardioverter defibrillator (ICD) recipients in 2010 were assessed according to home DHB, ethnicity and socioeconomic status using the NZDep index. A total of 352 new ICDs were implanted nationwide during 2010, yielding an overall implantation rate of 80.6/million. There was substantial variance in implant rates across the 20 DHBs with the highest implant rate observed in Tairāwhiti at 192.3/million, and the lowest at 22/million in the Nelson region. Implant rate also varied significantly by ethnicity, with Māori ethnicity at an implant rate of 114/million, European patients at 83/million, Pacific Island patients at 47/million and Asian patients at an implant rate of 32/million. Socioeconomic decile had no significant effect upon number of implants.

**Comment:** I've included this paper to highlight the fact that 'not all things are equal'. So when the authors suggest that people living in Tairāwhiti and Māori have higher implant rates than others, I'd argue that there is greater need for implants in these two populations. In fact, Māori are twice as likely to die from CVD than NZ Europeans, and therefore Māori should be receiving ICDs at twice the rates of NZ Europeans. Instead, the rates are only 1.4 times higher; therefore Māori are missing out!

**Reference:** *Heart Lung Circ.* 2012 May 15. [Epub ahead of print]

<http://www.sciencedirect.com/science/article/pii/S1443950612002417>

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