

Māori Health Review

Making Education Easy

Issue 14 – 2008

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Tena koutou, tena koutou, tena taatou 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. Otira ka mhih aroha ki a Paratene Ngata ratou ko Ngaroma me a raua tamariki mokopuna. Noho ora mai Matire

Greetings

Welcome to this issue of the Māori Health Review. I hope you enjoy the latest issue.

On a sad note, as some of you may know, Dr Paratene Ngata is not well. He has contributed immensely to Māori health, as clinician, teacher, advocate and leader. And not without support from Ngaroma and the rest of his whanau. I therefore wish to extend my love to Paratene and Ngata whanau.

Stay well, regards

Matire

Dr Matire Harwood

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Innovation and effectiveness: changing the scope of school nurses in New Zealand secondary schools

Authors: Kool B et al

Summary: This study conducted annual semi-structured school nurse interviews and analysed routinely collected school health service data in eight New Zealand secondary schools from low socioeconomic areas with high Pacific Island and Māori rolls, from 2002 to 2005. Two patterns of school nurse operation were identified: an embracing pattern, where nurses embraced the concept of providing school-based health services; and a Band-Aid pattern, where only the basics for student health care were provided by school nurses.

Comment: These results confirm the important role of school nurses in the provision of health care and education for tamariki and rangatahi. School boards should work with their school nurses if they wish to see an 'embracing pattern of practice' rather than the 'band aid' approach. I suggest that job satisfaction for school nurses would improve also when they are supported at a regional or national level, have a career pathway including assistance to receive appropriate education and can work with the community/pupils to ensure the service will meet their needs.

Reference: *Aust N Z J Public Health. 2008;32:177-80*

<http://dx.doi.org/10.1111/j.1753-6405.2008.00197.x>

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Ethnic differences in the management of lung cancer in New Zealand

Authors: Stevens W et al

Summary: This audit of secondary care management in Auckland and Northland of lung cancer patients diagnosed in 2004 aimed to assess whether management differences exist according to different ethnic groups, which may contribute to ethnic survival disparities. Of 565 eligible cases, 378 were European (67%), 95 were Māori (17%), 56 Pacific Peoples (10%), 23 Asian (4%), and 13 other or unknown ethnicity (2%). Multivariate analyses adjusted for tumour and patient factors including comorbidity revealed that Māori were 2.5 times more likely to have locally advanced disease than localised disease compared with Europeans ($p < 0.01$), and four times less likely to receive curative rather than palliative anticancer treatment compared with Europeans ($p < 0.01$). Māori had longer transit times from diagnosis to treatment ($p < 0.001$). Māori were more likely to decline treatment and miss appointments than Europeans, although this only partially explained management differences.

Comment: This highlights the importance of undertaking clinical audit along the care pathway – particularly in lung cancer management given that it is a leading cause of cancer and deaths for Māori. ‘Declining’ or missing appointments occurs for any number of reasons, many of them outside the patient’s control. Despite this, many clinicians and reception staff record ‘DID NOT ATTEND’ or ‘DNA’ in the patient notes without further information. Some clinicians admit that they are more likely to negatively stereotype a patient with ‘DNA’ recorded in their notes as non-compliant/difficult. Whether this has implications in the delivery of care is yet to be determined. Studies to explain unequal treatment rates between Māori and non-Māori are currently underway for IHD, colon cancer and other diseases – perhaps similar research in lung cancer should be a priority.

Reference: *Journal Thorac Oncol.* 2008;3:237-44

www.jto.org/pt/re/jto/abstract.01243894-200803000-00007.htm

Intimate partner violence and women’s physical and mental health in the WHO multi-country study on women’s health and domestic violence: an observational study

Authors: Ellsberg M et al

Summary: This WHO multi-country study interviewed women aged 15–49 years between 2000 and 2003 about their experiences of physically and sexually violent acts by a current or former intimate male partner, and about selected symptoms associated with physical and mental health. The women reporting physical violence by a partner were asked about injuries that resulted from this type of violence. 24,097 women completed interviews. Women who had experienced partner violence had worse self-reported health than women without such experiences, and specific health problems in the previous 4 weeks such as difficulty with walking and daily activities, pain, memory loss, dizziness, and vaginal discharge. Women who reported partner violence at least once in their life reported increased emotional distress and suicidal thoughts or attempts, compared with non-abused women.

Comment: Although women living in NZ were not recruited into the study I have included this paper because the results clearly demonstrate that the impact of partner violence on women’s physical and mental health occurs for women of many nations and varied backgrounds. As health providers we must address the major health needs for women who have experienced partner violence; as whanau, communities and nations we should also protect their rights to a healthy life.

Reference: *Lancet.* 2008;371:1165-72

[http://dx.doi.org/10.1016/S0140-6736\(08\)60522-X](http://dx.doi.org/10.1016/S0140-6736(08)60522-X)

*Independent commentary by Dr Matire Harwood,
Medical Research Institute of New Zealand*

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Risk factors for hospitalisation due to diabetes complications

Authors: Tomlin AM et al

Summary: This study determined risk factors monitored in primary care that were significantly associated with diabetes complications requiring hospitalisation, using clinical and demographic data for 1080 type 1 and 11,283 type 2 New Zealand diabetes patients attending a free primary care diabetes examination between 2000 and 2002. Hospital admissions data for the 2 years following the index examination were linked for each patient using a unique National Health Index code. Hospitalisations for diabetes complications occurred in 222 cases (20.6%) in the type 1 cohort and in 1948 cases (17.3%) in the type 2 cohort. In both cohorts, patients admitted with diabetes complications had significantly higher mean glycosylated haemoglobin (HbA_{1c}) and triglyceride levels, urine albumin:creatinine ratios and duration of diabetes than patients not admitted. In type 2 patients, age, obesity, HbA_{1c}, urine albumin:creatinine ratios, HDL levels and treatment with insulin or oral medication increased the likelihood of admission.

Comment: This study has importantly identified risk factors for hospitalisations in patients with diabetes. For primary care providers, the results confirm the need to aggressively screen for and manage these risk factors in order to prevent diabetes complications.

Reference: *Diabetes Research and Clinical Practice. 2008;80:244-52*
<http://dx.doi.org/10.1016/j.diabres.2007.12.017>

“If everyone does it, it’s not a big deal.” Young people talk about Chlamydia testing

Authors: Rose SB et al

Summary: Young people’s attitudes to Chlamydia testing were explored through four single sex focus groups conducted with 16–24 year old males and females (n=28), and one with health professionals working with this age-group (n=7). Semi-structured interviews discussed barriers to Chlamydia testing, methods of accessing testing, communicating information about Chlamydia and ideas about ways to encourage testing. Young people cited fear, stigma, denial of personal risk, and a lack of knowledge about Chlamydia and about testing procedures, as reasons for not seeking testing. Better education and a need to ‘normalise’ testing were suggested as ways to increase test-uptake. Preferences for places to seek testing varied among participants, but all groups supported routinely offered Chlamydia testing when visiting the doctor for other reasons. Participants also favoured the concept of home-testing.

Comment: Suggests that GPs and practice nurses should consider opportunistic education and possibly testing for Chlamydia when seeing their young patients for other reasons.

Reference: *N Z Med J. 2008;121 (1271):33-42*
<http://www.nzma.org.nz/journal/121-1271/2981/>

Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach

Authors: Wills R et al

Summary: A formal organisational change approach was introduced into a mid-sized regional health service, to implement the New Zealand Family Violence Intervention Guidelines and thereby improve detection and quality of assessment of child and partner abuse within the service. More than 700 staff were trained in dual assessment for child and partner abuse. Pre-post evaluations demonstrate improved confidence following training, though staff still need support. Barriers and enablers to asking about partner abuse were identified. Referrals from the health service to the Department of Child, Youth and Family Services increased from 10 per quarter to 70 per quarter. Identification of partner abuse increased from 30 to 80 per 6-month period. Routine questioning rates for partner abuse vary between services.

Comment: An important paper for those of us wishing to improve health outcomes through the implementation of best practice guidelines. Although I had some questions about the findings (did improved rates of identification and quality of assessments lead to better outcomes for children and partners?), the study did provide valuable information about ways to improve the way in which a service is delivered. Commitment from all staff in the organisation (including senior managers), collaboration with the community and other stakeholders, sufficient resources/time to support the changed practice and ongoing research, evaluation and training are required.

Reference: *J Paediatr Child Health. 2008;44:92-8*
<http://dx.doi.org/10.1111/j.1440-1754.2007.01276.x>

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Beyond Te Whare Tapa Whā: What do we want NZ medical graduates to know about Māori health?

Authors: Jones R et al

Summary: Increasing evidence attests to the fact that Māori receive poorer quality care than non-Māori in the New Zealand health system, and that health care professionals contribute to these inequalities. Medical graduates need to be culturally competent, deliver care equitably to all patients, and be committed to improving Māori health outcomes. While Hauora Māori is included in New Zealand's medical school curricula, the way it is taught and assessed varies considerably. This paper communicates the vision for Māori health teaching and learning at the University of Auckland and seeks feedback on this approach. It presents an overview of work being undertaken to develop and integrate the Hauora Māori curriculum in medical training, including a broad outline of proposed Hauora Māori learning outcomes, teaching and learning activities and assessment methods within undergraduate medical education.

Comment: As a colleague often asks me, what do we want the NZ medical graduate to be? Rhys and others at the Auckland medical school have opened discussion in this paper which he presented at the recent Te ORA hui. The next step is to pin down some of the 'learning outcomes' but as Rhys says, this may be more difficult.

Te ORA has not included a link to this article as yet on its website, so Rhys Jones invites readers to link to his webpage at Te Kupenga Hauora Māori:

https://www.fmhs.auckland.ac.nz/faculty/staffct/staff_details.aspx?staffID=726A6F6E303138

Factors associated with restoration and extraction receipt among New Zealand children

Authors: Jamieson LM and Koopu PI

Summary: Demographic socioeconomic, physical/lifestyles, dietary, food security and dental factors contributing to restoration or extraction receipt were assessed among 3,275 New Zealand children aged 5–14 years (37.4% were Māori, 32.3% Pacific and 30.3% NZ European and Other [NZEO]). Māori children had higher odds of having received a restoration than NZEO children after adjusting for age, gender and length of time lived in New Zealand and with addition of household SES, lifestyle, dietary, food security or dental factors. By contrast, Pacific children had higher odds of having received an extraction than NZEO children when age, gender and length of time lived in New Zealand were taken into account, and with addition of household SES, lifestyle, dietary, food security or other dental factors.

Comment: This paper highlights the significant ethnic disparities in dental health outcomes in Aotearoa and provides evidence for the association between oral health and deprivation (lower socioeconomic status or reduced availability/access to nutritious food) for Māori and Pacific children. Public health strategies are required alongside other prevention programmes (access to fluoridated water, regular dental checks).

Reference: *Community Dent Health.* 2008;25:59-64
<http://dx.doi.org/10.1922/CDH.2146Jamieson06>

The impact of racism on Indigenous health in Australia and Aotearoa: Towards a research agenda

Authors: Paradies Y et al

Summary: This report summarises findings from a symposium on racism and Indigenous health held in Australia, November 2007. This symposium involved 35 researchers and policy-makers from Australia and Aotearoa in the area of racism and Indigenous health to discuss recent findings in this field and to set an agenda for future research. The symposium presents clear evidence that racism detrimentally affects the health of Indigenous peoples in Australia and New Zealand and highlights the need for further research to understand the extent and nature of racism, and to determine how it can be effectively addressed.

Comment: A great resource for Māori health researchers and providers, the discussion at the symposium addressed a number of important questions including 'how to measure the prevalence and experience of racism for Indigenous peoples' and 'how do we address systemic racism'. It covers concepts and definitions, the extent of racism and its impact on health. As the authors state, sound research is required.

Reference: *Discussion Paper No. 4, Cooperative Research Centre for Aboriginal Health, Darwin*
www.craah.org.au/publications/downloads/Racism-Report.pdf

Did it fall or was it pushed? The contribution of trends in established risk factors to the decline in premature coronary heart disease mortality in New Zealand

Authors: Tobias M et al

Summary: Risk factor prevalence data by 10-year age group (35-64 years) and sex was examined from six national or Auckland regional health surveys and three population censuses to estimate the contribution of trends in three risk factors – systolic blood pressure (SBP), total blood cholesterol (TBC) and cigarette smoking – to the decline in premature coronary heart disease (CHD) mortality in New Zealand from 1980–2004. Approximately 80% (73% for males, 87% for females) of the decline in premature CHD mortality from 1980 to 2004 is estimated to have resulted from the joint trends in population SBP and TBC distributions and smoking prevalence. Overall, approximately 42%, 36% and 22% of the joint risk factor effect was contributed by trends in SBP, TBC and smoking respectively.

Comment: Useful information for primary care services and/or PHOs. The study showed that 'averages' for readily available measures such as BP, cholesterol levels and smoking rates declined over the 24-year period and the decline was associated with reduced CHD mortality. Services may therefore wish to collect and analyse the same data from eligible patients in order to monitor health outcomes (CHD mortality) within the service. Reducing BP, managing blood cholesterol levels and supporting people to quit smoking are major priorities to improve CHD outcomes, particularly for Māori.

Reference: *Aust N Z J Public Health.* 2008;32:117-25
<http://dx.doi.org/10.1111/j.1753-6405.2008.00186.x>

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