

Māori Health Review™



Making Education Easy

Issue 73 – 2018

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Abbreviations used in this issue

AF = atrial fibrillation
CHA₂DS₂-VASc = clinical prediction rule for estimating the risk of stroke in patients with nonrheumatic atrial fibrillation
DHB = District Health Board
QALYs = quality-adjusted life-years

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Ngā mihi

Matire

Dr Matire Harwood

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A review of cervical cancer occurrences in New Zealand 2008–2012

Authors: Hider P et al.

Summary: These researchers reviewed screening histories of women diagnosed with confirmed or possible cervical cancer between 1 January 2008 and 31 December 2012 in order to identify where improvements could be made to the National Cervical Screening Programme. A total of 772 confirmed diagnoses of cervical cancer were identified; the incidence rate was 6.9 per 100,000 women per year. Of 644 women aged 25–69 years with cervical cancer, just 13% had undergone regular cervical cancer screening according to national guidelines. Pacific and Asian Women (54% and 59%, respectively) were less likely than European or Māori women (76% and 73%, respectively) to have ever had a cervical screen. Adequate screening (defined as no between-screen interval of more than 3 years during the 6 months to 7 years before diagnosis) was low amongst Māori and Pacific women (6% and 5%, respectively) and less than that of European or Asian women (18% and 11%, respectively). Women residing in areas of greater socioeconomic deprivation were less likely to have had screens at most time intervals and were less likely to have regular screens than women who were residing in less deprived areas. A significant proportion (37%) of women who developed cervical cancer had undergone screening in the preceding 3-year screening interval prior to their cancer diagnosis.

Comment: As primary prevention and early diagnosis are key to eliminating the remaining inequalities in cervical cancer between Māori and non-Māori women, it is critical that we focus on improving screening rates. From experience, hard work, a clinic champion to lead the team and a programme that focuses on achieving equity (i.e. developed to work for women missing out) have proven effective.

Reference: *N Z Med J. 2018;131(1472):53-63*

[Abstract](#)

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.



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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.

Research Review publications are intended for New Zealand health professionals.

Ethnic disparities in attendance at New Zealand's chronic pain services

Authors: Lewis GN et al.

Summary: These researchers sought to determine how well DHB chronic pain services serve the diverse ethnic population in NZ and the clinical presentation of patients attending the clinics. Demographic data of patients attending for an initial assessment in 2015 were requested from all DHBs that offered a multidisciplinary chronic pain service. Overall, Europeans were over-represented at the services by 9%, while Pasifika and Asians were under-represented by 58% and 49%, respectively. Māori patients had significantly poorer scores than Europeans in all clinical assessment measures, while Pasifika and Asian patients scored significantly worse than Europeans on the majority of measures on clinical assessments.

Comment: Having seen international studies showing ethnic disparities in pain care and outcomes, I was interested to see these NZ-based results. Importantly, the researchers have provided a useful 'audit-tool' for future monitoring of care and outcomes by ethnicity in NZ pain services.

Reference: *N Z Med J. 2018;131(1472):21-8*
[Abstract](#)

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Smoking prevalence among doctors and nurses—2013 New Zealand census data

Authors: Edwards R et al.

Summary: The 2013 New Zealand Census included 7,065 male and 5,619 female doctors, and 2,988 male and 36,138 female nurses; 2% of male and female doctors and 9% of male and 8% of female nurses were regular cigarette smokers. Corresponding rates in the 2006 Census were all higher: 4% of male and 3% of female doctors were regular cigarette smokers, as were 20% of male and 13% of female nurses. In the 2013 Census, psychiatric nurses had the highest smoking prevalence (15% male, 18% female). Smoking was more common among Māori doctors (6.8%) and nurses (19.3%). Around 96% of young (<25 years) doctors and 87% of young nurses had never been regular smokers.

Comment: See next paper.

Reference: *N Z Med J. 2018;131(1471):48-57*
[Abstract](#)

Impact of five tobacco endgame strategies on future smoking prevalence, population health and health system costs: two modelling studies to inform the tobacco endgame

Authors: van der Deen FS et al.

Summary: Using the NZ Smokefree goal for 2025 as a case study, these researchers modelled the impacts on smoking prevalence, health gains (quality-adjusted life-years [QALYs]) and cost savings of (1) 10% annual tobacco tax increases, (2) a tobacco-free generation, (3) a substantial outlet reduction strategy, (4) a sinking lid on tobacco supply and (5) a combination of 1, 2 and 3. The analysis included two models: (1) a dynamic population forecasting model for smoking prevalence and (2) a closed cohort (population alive in 2011) multistate life table model (including 16 tobacco-related diseases) for health gains and costs. All selected tobacco endgame strategies were associated with reductions in smoking prevalence by 2025, down from 34.7%/14.1% for Māori/non-Māori in 2011 to 16.0%/6.8% for tax increases; 11.2%/5.6% for the tobacco-free generation; 17.8%/7.3% for the outlet reduction; 0% for the sinking lid; and 9.3%/4.8% for the combined strategy. Major health gains accrued over the remainder of the 2011 population's lives ranged from 28,900 QALYs (95% Uncertainty Interval [UI] 16,500 to 48,200; outlet reduction) to 282,000 QALYs (95% UI 189,000 to 405,000; sinking lid) compared with business-as-usual (3% discounting). The timing of health gain and cost savings greatly differed for the various strategies (with accumulated health gain peaking in 2040 for the sinking lid and 2070 for the tobacco-free generation).

Comment: Two studies highlighting the need for urgent strategies that support Māori to be smokefree. As the authors for both papers suggest, innovative ideas are now required. However, the concept of having a 'smokefree culture' seems effective.

Reference: *Tobacco Control. 2018;27:278-86*
[Abstract](#)

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Dementia: Supplementary Findings from LiLACS NZ for Section Five, 'Service Use and Common Health Conditions' in the report 'Health, Independence and Caregiving in Advanced Age'

Funded by the Ministry of Health, the University of Auckland released the report *Dementia: Supplementary Findings from LiLACS NZ for Section Five, 'Service Use and Common Health Conditions'* in the report *'Health, Independence and Caregiving in Advanced Age'* on the 10th of May 2017. This report establishes how the presence of dementia affects older Māori and non-Māori (aged 80 years and above), and the services they use when the dementia patients also have cardiovascular disease, chronic lung disease and diabetes mellitus.

The study found that dementia was associated with lower functional status, higher frailty, poorer mental and physical health-related quality of life and higher health service use and cost. The combination of dementia with any of the physical health conditions studied in the report (cardiovascular disease, chronic lung disease, and diabetes mellitus) worsened health status and increased health service use and costs.

The project *Te Puāwaitanga O Ngā Tapuwae Kia Ora Tonu/ Life and Living in Advanced Age, a Cohort Study in New Zealand (LiLACS NZ)* is a longitudinal cohort study of New Zealanders in advanced age. LiLACS NZ is the world's first longitudinal study of an indigenous population aged 80 and over.

The report, along with the 13 previously released LiLACS NZ reports, can be found at the University of Auckland website:

<https://www.fmhs.auckland.ac.nz/en/faculty/lilacs/research/publications.html>



Mahi a Atua: a pathway forward for Māori mental health?

Authors: Rangihuna D et al.

Summary: This article discusses outcomes from pilot project evaluating a kaupapa Māori approach to mental health in primary care – the Mahi a Atua narratives-based programme established in the primary mental healthcare services of the Tairāwhiti/Gisborne area. As the article explains, not only is the demand from Māori on New Zealand mental health services out of proportion to the size of the Māori population, but the psychiatric service response is limited by lack of capacity as well as lack of capability. The Western paradigm psychiatric service is embedded in a biomedical cause of disease and its treatment regime involving psychotherapeutics, medication and seclusion cannot accommodate the relationships, meaning, values, beliefs and cultural practices that are important to Māori. The Mahi a Atua approach to mental health (tracing the ancestral footsteps of the Gods) is being offered under the Ministry of Health's Mental Health and Addictions Project, "Fit for the Future – a Systems Approach". The article makes the point that this new approach to psychiatric assessment, diagnosis and therapy is appropriate, but not restricted, to the Māori community.

Comment: A great paper, and service, particularly when an article reviewed in the last issue of MHR showed that Māori presenting to mental health services were not being asked if they would prefer to see a Māori health team.

Reference: *N Z Med J.* 2018;131(1471):79-83

[Abstract](#)

Burden of atrial fibrillation in Māori and Pacific people in New Zealand: a cohort study

Authors: Gu Y et al.

Summary: This analysis involved electronic medical records for 135,840 adults (aged ≥20 years), including 19,918 Māori and 43,634 Pacific people, enrolled at 37 NZ general practices for AF diagnosis and associated medication prescription information. The overall prevalence of non-valvular AF (NVAf) was 1.3% (n=1,769) and increased with age (4.4% in those aged ≥55 years). Māori aged ≥55 years were more likely to be diagnosed with NVAf (7.3%) than Pacific (4.0%) and non-Māori/non-Pacific people (4.1%; p<0.001). Māori and Pacific NVAf patients were diagnosed with AF 10 years earlier than non-Māori/non-Pacific patients (median age of diagnosis: Māori = 60 years, Pacific = 61 years, non-Māori/non-Pacific = 71 years; p<0.001). Two-thirds (67%) of the NVAf cohort were at high risk of stroke (CHA₂DS₂-VASc ≥2) at the time of AF diagnosis. Among patients aged <65 years, almost half (48%) of Māori and Pacific NVAf patients were at high risk for stroke, over double the rate (22%) for non-Māori/non-Pacific (p<0.001). Irrespective of ethnic group, adherence to AF medication was suboptimal in those NVAf patients with a high risk of stroke or with stroke history.

Comment: This paper received a lot of media attention, as it highlighted the need to 1: Understand the different health contexts for Māori and Pacific people, and 2: That a 'different' process may be required (i.e. younger age for screening and management) to achieve health equity. You can see more here - <https://www.youtube.com/watch?v=3qfemRq5cQg>

Reference: *Intern Med J.* 2018;48(3):301-9

[Abstract](#)

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Inclusion of equity in economic analyses of public health policies: systematic review and future directions

Authors: Lal A et al.

Summary: This systematic review identified 29 studies that had used socioeconomic position (SEP) in cost-effectiveness analyses of public health interventions. Studies were evaluated based on their specific inputs in regard to socioeconomic position and how they quantified health and financial inequalities. The study researchers specifically sought to assess current approaches to inclusion of equity in economic analysis of public health interventions and to recommend best approaches and future directions. The majority of studies comparing ≥2 interventions left interpretation of the size of the health and financial inequality differences to the reader. Newer approaches include: i) use of health inequality measures to quantify health inequalities; ii) inclusion of financial impacts, such as out-of-pocket expenditures; and iii) use of equity weights.

Comment: For me, this paper highlights the need for a kaupapa Māori health economic analysis to better support/guide/inform funding and planning decisions.

Reference: *Aust N Z J Public Health.* 2018; 42(2):207-13

[Abstract](#)

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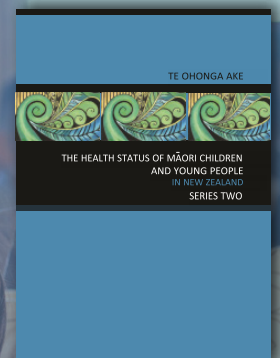
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Te Ohonga Ake: The Health Status of Māori Children and Young People in New Zealand Series Two was released on 23 June 2017.

The publication was funded by the Ministry and produced by the New Zealand Child Youth and Epidemiology Service (NZCYES) at the University of Otago. The sections that are presented in the publication include: issues in infancy, issues for ages 0-24 years, respiratory system conditions, communicable diseases, unintentional injuries, reproductive health and mental health.

The publication (along with previous reports in the Te Ohonga Ake series) can be accessed at: <https://ourarchive.otago.ac.nz/handle/10523/7390>



Looking like a smoker, a smokescreen to racism? Māori perceived appearance linked to smoking status

Authors: Muriwai E et al.

Summary: In this analysis of a national probability sample of 667 self-identified Māori, the study researchers examined links between subjective elements of Māori identity, demographic factors and perceived discrimination with smoking status. According to their evidence, smoking was not linked in any significant way to core aspects of Māori identity and cultural engagement. However, a clear association was observed between the extent to which participants felt they were perceived as prototypically Māori (measured as Perceived Appearance) and the likelihood of smoking. The effect of Perceived Appearance persisted in analyses adjusted for perceived experiences of discrimination and other standard demographic indicators.

Comment: I enjoy reading the papers from these authors as they address such interesting questions and provide evidence to link racism and health or health behaviours. As discussed above, a multi-pronged approach is required for a Te Ao Māori that is smokefree – strategies that address racism must be included in this approach.

Reference: *Ethn Health. 2018;23(4):353-66*

[Abstract](#)

Becoming active: more to exercise than weight loss for indigenous men

Authors: Warbrick I et al.

Summary: This qualitative investigation explored the experiences of 23 sedentary NZ Māori men participating in a 12-week exercise intervention to improve their metabolic health. Thematic analysis of the data sought to understand what motivates sedentary indigenous and ethnic minority men to become more physically active. Four themes were evident: The Bros – having fellowship and mutual motivation; Being better informed about exercise; Impacting overall wellbeing; and Disseminating the findings beyond the study. When exercise interventions were informed by indigenous Māori cultural values and knowledge, the participants considered that the exercise was more relevant to their daily lives. These men were motivated more by culturally-based external factors than an inherent desire to lose weight.

Comment: The authors make a great point that whilst we may think 'weight loss' is a worthy objective, it is more important to understand what motivates the person, and tailor the program accordingly.

Reference: *Ethn Health. 2018 Mar 27. [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.

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Asking the difficult questions: Building the capacity of community paediatricians to routinely enquire and respond to family violence

Authors: Gibbons CL et al.

Summary: This Australian research group reviewed the literature for data on family violence education programmes and evidence-based family violence screening tools. They then developed a series of six education sessions, which were delivered to physicians at the Community Paediatric and Child Health Service (CPCHS) in Canberra. These sessions were designed with the aim of enhancing the confidence and capacity of community paediatricians and paediatric trainees to identify and respond to family violence. An audit was performed on the charts of all new referrals to the CPCHS over an 18-month period prior to the education sessions and for 5 months following the education sessions. The documented rate of enquiry into family violence at CPCHS increased 4-fold from 24% in the retrospective chart audit to 60% following the education sessions (OR 4.7; p<0.05). In addition, the documented rate of disclosure of family violence increased 2-fold, from 13% of all new patients in the retrospective chart audit to 24% following the education sessions (OR 2.1; p<0.05). A questionnaire distributed after the education sessions revealed that all participants routinely enquired about family violence and were comfortable enquiring about family violence.

Comment: I've had difficulties enquiring about family violence with whānau. However, attending the training and having the standard questions/guidelines has been immensely useful. I now understand the contexts or environments in which family violence is more likely to occur (stress, poverty, housing issues), that whānau have a right to live their lives free of violence, and that I have an important role addressing the upstream 'risks' and preventing the downstream effects.

Reference: *J Paediatr Child Health. 2018;54(3):234-7*

[Abstract](#)

Inequities in exposure to occupational risk factors between Māori and non-Māori workers in Aotearoa New Zealand

Authors: Denison HJ et al.

Summary: For this study, the researchers sampled potential participants from the NZ electoral rolls and invited them to take part in a telephone interview, which included questions about current workplace exposures. The investigation assessed differences in the prevalence of self-reported exposure to disease risk factors, including dust and chemicals, physical factors and organisational factors, between 2,344 Māori and 2,710 non-Māori workers. Exposure to occupational risk factors was more likely for Māori than non-Māori. For dust and chemical exposures, the main differences related to Māori working in occupations where these exposures are more common. However, even within the same job, Māori were more likely than non-Māori to be exposed to physical factors such as heavy lifting and loud noise, and organisational factors such as carrying out repetitive tasks and working to tight deadlines.

Comment: A really important piece of work, as it looked at the workplace and its contribution to health inequities. I encourage all of us to investigate for potential inequities by gender, ethnicity, age, etc., in our workplaces, including in pay, professional development, health and safety outcomes. As Nazroo suggests, the health system is a major employer for Māori and we should perhaps start here.

Reference: *J Epidemiol Community Health. 2018 May 2. [Epub ahead of print]*

[Abstract](#)

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