Pacific Health Review

Making Education Easy

Issue 24 – 2015

In this issue:

Kia orana, Fakaalofa lahi atu, Talofa lava, Malo e lelei, Bula vinaka, Taloha ni, Kia ora, Greetings.

Welcome to Pacific Health Review.

Welcome to this edition of Pacific Health Review. We are pleased to be able to share with you a selection of recent publications with a focus on Pacific health. The topics of the research are diverse and cover a range of important issues, for example, childhood obesity, antibiotic prescribing in the community, palliative care, domestic violence, mental health and workforce specialisation. These diverse papers do have some common underlying themes which can be applied to our efforts to improve the health of Pacific people in Aotearoa/NZ. Here are my 3 take home messages from these studies.

The first is the importance of addressing the socioeconomic determinants of health. While navigating complex health systems and treatments is hard for anyone, these studies add to the small evidence base for Pacific health that shows that ethnicity/culture, health literacy and socioeconomic factors are additive and impact in ways that we need to understand better. My second point is the challenge which arises from reorienting our current systems and focus on meeting the needs of the individual, to flexibility to respond to Pacific communities' family centred and communal approaches. Finally, to strengthen the evidence base for policy making and practice, we need research using diverse methods, and importantly, including research methods which capture the worldviews and lived experiences of Pacific people, families and communities.

Thank you to all our contributors to this edition of Pacific Health Review. We welcome your feedback.

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Maternal cultural orientation and child growth in New Zealand Pacific families

Authors: Tseng M et al.

Summary: This study followed a birth cohort of 1249 New Zealand children of Pacific heritage from 2000 through 2011. Birth weight, weight and standing height were measured at years 2, 4, 6, 9, and 11. Maternal acculturation was assessed at baseline and years 4, 6, and 11. In adjusted models using generalised estimating equations to account for repeated measures, maternal acculturation was not significantly associated with children's weight-for-age (WFA) or BMI z-scores overall. In stratified analyses, change in maternal acculturation score was inversely associated with WFA z-score change among children of NZ-born, but not immigrant, mothers (beta=–0.021; 95% CI, –0.036 to –0.007; p=0.006).

Comment (Sameli Tongalea): Obesity is a growing concern for future Pacific generations in New Zealand. This paper reports on the findings of the first longitudinal study that focused on maternal acculturation and whether this had any impact of the growth and development of Pacific children, in particular their weight. The study was conducted with a cohort of Pacific infants born in South Auckland over a period of 10 months, whose mothers had either migrated to New Zealand or were New Zealand-born and covered their ages from 2, 4, 6, 9 and 11 years.

The study showed that maternal acculturation occurred irrespective of whether the mother was New Zealand-born or Pacific-born. Additionally, while acculturation can be deemed a contributing factor for weight gain in Pacific children due to maternal behaviours and environmental influences, e.g. high-deprivation areas with numerous fast food outlets, maternal adjustments to their "society", this needed to be contextualised further with the influences of cultural values and beliefs, combined with the dynamics of traditional childrearing practices, roles and expectations of mothers, within Pacific families. These factors in themselves could provide a pathway for further discussions, in consideration of the way that these factors can make maternal and familial acculturation positive experiences, as we work to improve the health and wellbeing of future Pacific generations. Furthermore, it would be of interest to explore whether maternal acculturation is different for children whose mothers reside in areas other than South Auckland.

Reference: Child Obes. 2015;11(4):430-8
Abstract

'No matter what the cost': A qualitative study of the financial costs faced by family and whaanau caregivers within a palliative care context

Authors: Gott M et al.

Summary: This Auckland-based group of researchers explored family and whānau carers' experiences of the financial impact of caring within a palliative care context. Semi-structured interviews were held with 30 family/whānau caregivers who were either currently caring for a person with palliative care needs or had done so in the past year. Narrative analysis identified impacts and costs at the personal, interpersonal, sociocultural and structural levels. Participants reported significant costs involved in caregiving, resulting in debt for some people or even bankruptcy. A range of direct (transport, food and medication) and indirect costs (related to employment, cultural needs and own health) were reported. A multi-level qualitative analysis revealed how costs operated at a number of levels (personal, interpersonal, sociocultural and structural). The palliative care context increased costs, as meeting needs were prioritised over cost. In addition, there was confusion among caregivers as to what statutory (government) help was available in the context of 'being palliative'.

Comment (Lisa Kitione): Focusing attention on the financial costs for families providing palliative care, this study raises some important issues about the realities and support needs of Pacific family caregivers, both in a palliative care and broader context.

It is estimated that family caregivers provide about 75–90% of home-based end-of-life care. However, with evidence suggesting that many Pacific people develop palliative care needs at a younger age[1] and the high prevalence of chronic conditions in Pacific populations (that often do not meet 'palliative' definitions), greater levels of complex caregiving are required from many Pacific families. Within this context, the study's assertion, that caregiving cost burdens will be disproportionately felt by families with already stretched resources, is significant. Poor socioeconomic circumstances (neighbourhood deprivation, limited financial resources) known to play a significant role in Pacific health outcomes, magnify the costs, pressures and risks faced by Pacific families. In these situations, the financial costs of caregiving for families identified in the research, both direct (transport, parking, medications) and indirect (lost income, unpaid leave), can represent a tipping point in the precarious balance of managing caregiving and daily demands.

Pacific family caregiving often takes place within a setting of large, often multigenerational and multilingual households, with value systems strongly rooted in Pacific traditions and beliefs. The researchers rightly emphasise the use of culturally appropriate methodologies to include groups most affected by caregiving costs – vital for capturing unique experiences of Pacific families. Furthermore, the uncertainty amongst participants about existing palliative care assistance and available supports for accessing financial help (that echo well-documented issues for Pacific families) presents a strong argument for including families in any policy analysis about the future provision of palliative care services. In a broader sense, the research reinforces the support needs of Pacific family caregivers, in a variety of different health settings, as central to the health and wellbeing of the family unit as a whole. Meaningful and coordinated system responses are essential for positive long-term outcomes.

1. Palliative Care Council of New Zealand (2011). National Health Needs Assessment for Palliative Care - Phase 1 Report: Assessment of Palliative Care Need. Available online: http://www.health.govt.nz/system/files/documents/publications/national-health-needs-assessment-for-palliative-care-jun11.pdf

Reference: Palliat Med. 2015;29(6):518-28
Abstract

The role of medical generalism in the NZ health system into the future

Author: Atmore C

Summary/Comment (Api Talemaitoga): The author, Dr Carol Atmore, is a well-respected GP who works for the Transalpine Health Services, a generalist, specialist and sub-specialist workforce model developed by the West Coast and Canterbury District Health Boards.

Dr Atmore makes the point that with the changing demographics and the burden of chronic disease of the New Zealand population, it is important that the Ministry of Health considers the current mix of doctors' skills and expertise in New Zealand is fit for purpose for the future.

My own comments: thought should also be given to the changing ethnic mix of the New Zealand population and whether the health professionals servicing the population reflect this change.

There is increasing incidence of long-term conditions, an ageing population, increasing obesity and ongoing social inequalities. Sub-specialisation will not address these issues holistically – care will be fragmented, more expensive and quality of care will be compromised. On the other hand, doctors serving these communities need to be part of a multidisciplinary team including nurses, allied health workers, patients and their whānau, dealing with the complexity of issues these people face daily

The last 60 years has shown an increased sub-specialisation of doctors. It has been done for mistaken/misplaced reasons, as is often associated with increasing prestige and remuneration. Consumer pressure and regulatory body changes has led to narrowing scopes of practice in an effort to increase standards of care provided to patients. In rural New Zealand, sub-specialisation has led to loss of flexibility in the range of services able to be provided at a local hospital.

There are also increased costs with the increasing fragmentation associated with specialization. One of the consequences has been a longstanding difficulty Grey Hospital has had in recruiting and retaining doctors – it has led to a high dependency on locum services to provide 24/7 rosters for each specialty area within the hospital setting. Not only is this costly; it also compromises the quality of care provided, as teams and teamwork are weakened.

It is important to note the countries that buck this trend of sub-specialisation – rural Scotland, rural Australia and rural Canada and the USA. They have encouraged generalism, with the emergence of 'hospitalists', individuals who work in a hospital setting but according to the health needs of the communities they serve. The generalist doctor in New Zealand is usually a GP – they provide 'whole person' care and recognise their limitations in skills and experience and when to elicit support, help and advice from their colleagues. These GPs tolerate uncertainty and manage tension and ambiguity. A large key to the success of this model is the development of high-trust relationships with skilled clinicians – doctors, nurses and allied health professionals at the Grey Hospital in rural New Zealand. It should also be noted that a generalist model has been shown to effectively co-exist with highly specialised services in an urban setting.

Dr Atmore makes the point that Health Workforce New Zealand (HWNZ) should seriously consider incentivising young doctors to consider being a generalist, which can include academic opportunities in research. Funding for this can be targeted to the Royal New Zealand College of General Practitioners and specialty colleges. HWNZ may also want to consider supporting senior doctors who wish to expand or refresh their skill set to operate in a more generalist way.

My own comments: this may also increase the longevity of practice for the older GPs and thereby help to manage the issues of the ageing medical workforce in this country.

Generalism will only work if there are effective local and regional health systems (developed by the doctors, nurses and allied health workers that work in them) with input from patients who use them, which have the support of management in the organisation. Dr Atmore challenges us to be a world leader in promoting generalism, actively recruiting and training generalists and redesigning our health system to meet the changing needs of the communities we serve and possibly maximising the benefits we get out of the (ageing) health workforce we have.

Reference: N Z Med J. 2015;128(1418):50-5
Abstract

CLICK HERE to read previous issues of Pacific Health Review

Pacific peoples, violence, and the power and control wheel

Authors: Rankine J et al.

Summary/Comment (Tamasailau Suaalii-Sauni): To make some headway on where a theory of violence prevention, implicit in the Duluth 'Power and Control Wheel' model ("the Duluth model") might begin for Pacific peoples, the discerning reader would benefit from reading this article. Jenny Rankine and her colleagues offer readers useful reflections on what they suggest as critical tension points between the Duluth model's and Pacific peoples' understandings of "the culture that support partner abuse and explain the gendered nature of DV [domestic violence]" (p.3). There are two tension points (in the main) that I wish to bring to the reader's attention: first, the point that male power and authority (patriarchialism) is natural, appropriate and good (whether suggestively ordained by The Divine or by Rational Government); and second, that this power and authority is 'individualised', not collective (i.e. "reflects an individualist culture where the abuser and victim are isolated from wider family intervention and change relies on the police and justice system"; p.5-6). Rankine et al. support the argument proposed by Crichton-Hill (2001) that both assumptions are problematic for Pacific indigenous peoples. I agree. But it's complicated.

The belief that domestic violence is overwhelmingly male is supported empirically by crime data from across all countries that collect such data. This is the case for both Pacific Island countries and for Pacific migrant communities in places like New Zealand. Moreover, within those Pacific societies and communities that are greatly influenced by patriarchal ideologies, there is a continuing, strong and widespread belief in male leadership as being both natural and divinely designated. Each of the migrant Pacific groups that Rankine et al. focus on come from explicitly Christian Pacific Island nation states. The significance of Christian values and beliefs to them is explicit in their Pacific Island Nation Constitutions and is obvious by the number of Christian churches that line the physical landscapes of their countries.[1] The discussion offered by Rankine et al. in this article on Pacific critiques of the Duluth model hints at a confluence of Christian/colonial and indigenous readings of patriarchialism. The history of this confluence complicates both Pacific peoples' renderings – and researcher interpretations of those renderings – of pre-contact values about gender/sexuality and gender roles and responsibilities (to which the authors refer) and their contemporary manifestations in modern Pacific domestic lives. Raising Pacific indigenous[2] concepts such as whānau, feagaiga, taupou, bulubulu, kaiga, faka'apa'apa, and so on, is at this point descriptive. To extend the critique in deeper ways the authors must be willing to at some point unravel the different theoretical points of departure between traditional, indigenous and contemporary ideas of gender, violence, and violence prevention and to travel to and fro between them in coherent and critical ways. This article alludes to such an objective; their next should explicitly engage with it.

This article makes a strong statement about the importance of making Pacific critiques of universalised models internationally visible to scholarly audiences. As any good article ought, given space constraints, it gives just enough in order not to frustrate the reader but to leave them still wondering and wanting to know more about the complexities of it all.

1. See for example Toeolesulusulu Damon Salesa's discussion on this point in: Salesa, T.D.I. 2014. "When waters met: some shared histories of Christianity and ancestral Samoan spirituality", In Whispers and Vanities: Samoan indigenous knowledge and religion. Suaalii-Sauni, T. et al (Eds). Wellington: Huia Publishers, pp.143-58.

2. I use the term 'indigenous' here in the sense offered by Gegeo and Gegeo when referring to indigenous knowledge in the development context, where the indigenous draws from the past, the present and the future. See: Gegeo, D. and K.A. Watson-Gegeo. 2002. "Whose knowledge?: Epistemological collisions in Solomon Islands community development". The Contemporary Pacific. 14(2):377-409, 381.

Reference: J Interpers Violence. 2015 Aug 12. [Epub ahead of print]
Abstract

Tracking food consumption frequency of children from age 4 to 6 years: the Pacific Islands Families study

Authors: Savila F et al.

Summary: These researchers analysed the data from a qualitative food frequency questionnaire that was administered at ages 4 and 6 years to caregivers (mostly mothers) of children from the Pacific Islands Families birth cohort. The aim of this investigation was to report food frequency information of New Zealand-born Pacific children and identify the foods being consumed before attending school (age 4 years) and at one year after starting school (age 6 years). The researchers also wanted to estimate tracking of consumption of food combinations. They hypothesised that consumption of similar foods would track and that, based on known high prevalence of overweight in the cohort, a high frequency of energy-dense foods (high in fat and/or refined carbohydrates) would persist across the two measurement periods.

Comment (David Schaaf): The strength of this paper is in the design of the original survey (The Pacific Islands Families Study). This is the very first cohort study involving Pacific infants from birth and their caregivers. The authors were able to use statistical means to provide some answers to what they set out to do (their research questions and hypothesis). They found that, for Pacific children living in New Zealand, from preschool (age 4 years) to the second year of school (age 6 years), the frequency of certain food and food groups remained relatively consistent. For example:

1. The 12 most frequently consumed foods (the top 12 foods) were identified, with bread, breakfast cereal and rice representing the top three most frequently eaten foods. The top 12 foods accounted for up to 25% of all food consumed on average per day. Overall, frequency of consumption of the top 12 foods remained moderately stable (r^2=0.53) across the two measurement periods (age 4 and 6 years). Eating bread and rice were the least likely to have changed, both remaining close to equilibrium across the two measurement periods. Chicken was the most frequently eaten meat. Snack foods, such as crisps and noodles (e.g. 2-minute noodles), remained popular. Food drinks (e.g. Milo™) and powdered fruit drinks (e.g. Raro™), which have sugar as a major component, were also frequently consumed foods at both ages.
2. The average daily consumption of food groups was very stable (r^2=0.96). The food groups of cereals and breads (26.5%) comprised the largest percentage of daily food portions across both measurement periods (ages 4 and 6 years). Around one-fifth of daily portions consisted of the meat and alternates (meats) food groups, while a quarter consisted of the vegetables (~15%) and fruit (~10%) food groups.

Overall, the finding from this research would add to the growing evidence to improve nutrition of Pacific children.

Reference: N Z Med J. 2015;128(1420):16-24
Abstract

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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.

Time spent reading this publication has been approved for CNE by The College of Nurses Aotearoa (NZ) for RNs and NPs. For more information on how to claim CNE hours please **CLICK HERE**

Socioeconomic factors correlating with community antimicrobial prescribing

Authors: Walls G et al.

Summary/Comment (Ellaine Ete-Rasch): The aim of this research was to explore **possible drivers of antimicrobial prescribing** in community settings. The threat of antibiotic resistance is a global public health concern and the use or misuse of antibiotics is suggested to be the driver for antibiotic resistance. This article is an important contribution to the literature on community antibiotic prescribing in New Zealand. With heightened concerns worldwide including New Zealand in regard to antibiotic resistance, it is important to identify and understand the possible causes for the spread of infections and why people are given antibiotics in the community. The findings highlight that household crowding has the strongest correlation with prescription rates. While this is not a surprise, as overcrowding increases the transmission of infections, this article adds to the evidence showing the important association of socioeconomic factors and infectious diseases. This article also reinforces the effects of crowded housing on health. Other risk factors for infectious diseases confirmed here are, children aged <15 years and adults aged ≥65 years, ethnic groups such as Pacific and Māori, and those who live in the most deprived areas.

Preventing Ambulatory Sensitive Hospitalisation (ASH) is important. The ASH rates for Pacific people are more than double that of the non-Māori/non-Pacific population and this has not changed over the past 4 years. Prescribing antibiotics in the community is a key way of minimising hospitalisation for infections. While this article was not designed to address this, infections are known to be the highest cause for acute hospitalisation in New Zealand. Therefore, it is important to have a better understanding of why people are prescribed antibiotics in the community in the first place.

The authors raise important points about the limitations of this study and the need to investigate the topic in more than one DHB. This is important, as New Zealand is thought to have higher human consumption and higher rates of prescribing antibiotics compared with other countries. A good understanding of what drives antimicrobial prescribing in the community and why people require antibiotics in the first place should lead to appropriate measures for minimising antibiotic resistance.

Finally, the message for general practitioners and nurse practitioners is to continue to review the appropriateness of prescribing antibiotics.

Reference: N Z Med J. 2015;128(1417):16-23
Abstract