Māori Health Review

Making Education Easy

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Tēnā koutou, tēnā koutou, tēnā tātou katoa

Ko tēnei te mihi mahana ki a koutou katoa. Nau mai ki tēnei tirohanga hou Hauora Māori. I tēnei putanga ka pāhotia ētahi kōrero whakahirahira mai i te hui o Te Ohu Rata o Aotearoa. Nō reira noho ora mai rā.

Matire

Greetings

Kia ora koutou katoa. Welcome to the second issue of Māori Health Research Review for 2010. It is certainly interesting times for Hauora Māori and Whānau Ora given recent events and changes over the past few months. I do however enjoy the bi-monthly opportunities to review research more thoroughly – it's a time to put my head up, take a look at the bigger picture and acknowledge some of the great work being done. Please continue to send through papers/studies that inspire you in your mahi also!

Noho ora mai, na

Matire
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Evaluation of a feasibility study addressing risk factors for childhood obesity through home visits

Authors: Wen LM et al

Summary: This report details the outcomes of a pilot study that addressed risk factors for childhood obesity through a home-based early intervention program conducted with 56 first-time mothers, recruited through the antenatal and delivery units of an inner western Sydney hospital. Mothers were offered five home visits by a community early childhood health nurse during the child's first year of life. At each visit, the intervention was tailored to the appropriate developmental stage of the child. One-to-one consultation was provided with a focus on sustained breastfeeding, appropriate introduction of solids, avoiding food rewards and promoting the drinking of water and the use of a cup. The program was very well received by the participating mothers, with a retention rate of 95%. Compared with the state population average, the rate of breastfeeding at 12 months was significantly higher (36% vs 18%; p<0.01), there was a lower rate of the introduction of solids before 4 months (2% vs 13%; p<0.01), and there was a high rate of cup usage at 12 months (98%).

Comment: I liked this study for a number of reasons. The team just 'got in there' and delivered a program that addressed a potentially 'sensitive' topic. The intervention is practical, easy to deliver and was associated with behaviour change. And finally, the researchers were able to show that mums liked it (retention rate of 95%!).

Reference: J Paediatr Child Health. 2009;45(10):577-81
http://www3.interscience.wiley.com/journal/122596600/abstract

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

Apologies to those of you who have already seen, or who use, this website – I only recently came across it! The Australian Indigenous Health Infonet is 'helping to close the gap by providing the evidence base' – similar to Māori Health Research Review but more flash! I think it's a great resource, particularly the Health Bulletin and Australian Indigenous Bibliography sections. I hope readers find it useful also. http://www.healthinfonet.ecu.edu.au/

I've selected two papers from the website. The first paper highlights the need for comprehensive implementation of clinical guidelines in order for Indigenous people to benefit from them. It is well documented that guideline implementation is a complex and multifaceted process. Strategies such as involving consumers and professional groups, implementing technological solutions, as well as providing incentives have been shown to be successful. But as the authors state, the lack of awareness and involvement with Aboriginal Community Controlled Health Services among most respondents will also limit the capacity to coordinate services.

Are the processes recommended by the NHMRC for improving Cardiac Rehabilitation (CR) for Aboriginal and Torres Strait Islander people being implemented?: an assessment of CR Services across Western Australia

Authors: Thompson SC et al

Summary: Recommendations issued in 2005 by the National Health and Medical Research Council (NHMRC), *Strengthening Cardiac Rehabilitation and Secondary Prevention for Aboriginal and Torres Strait Islander peoples: A Guide for Health Professionals*, have been poorly implemented in Western Australia (WA) within mainstream health services. Semi-structured interviews held between November 2007 and June 2008 with 24 health professionals involved in the WA Directory of cardiac rehabilitation (CR) services sought to describe health professionals' awareness, implementation, and perspectives of barriers to implementing these recommendations. Most respondents reported unfamiliarity with the NHMRC guidelines; thus, there was minimal implementation of the recommendations and inconsistent application. Respondents provided few in-patient CR-related services to Indigenous patients, services upon discharge were erratic, and few Indigenous-specific resources were provided for patients. Issues relating to workforce, cultural competence, and service linkages emerged as having most impact on design and delivery of CR services for Indigenous people in WA.

Reference: Aust New Zealand Health Policy. 2009;6:29.

http://www.anzhealthpolicy.com/content/6/1/29

The second paper I've included as an example of an innovative, and yet probably traditional, approach to health education.

Didgeridoo playing and singing to support asthma management in Aboriginal Australians

Authors: Eley R & Gorman D

Summary: These researchers report outcomes from a 6-month programme of once-weekly music lessons using a culturally significant wind instrument, the didgeridoo, for Aboriginal males and singing lessons for Aboriginal females, designed to increase their knowledge of asthma and support management of their asthma. All participants were asthmatics and were recruited from schools and through the rurally-based Aboriginal Medical Service. The programme produced noticeable improvements in respiratory function and health, was reportedly very enjoyable and had high retention rates. It also increased levels of cultural awareness among the didgeridoo players and noticeably improved girls' social skills.

Reference: J Rural Health. 2010;26(1):100-4.

http://www3.interscience.wiley.com/journal/123232439/abstract

Women's rugby league injury claims and costs in New Zealand

Authors: King D et al

Summary: Accident Compensation Corporation injury data from between 1999 and 2007 were analysed for women's rugby league injuries requiring medical treatment and associated costs in New Zealand. A total of 320 female moderate to serious (MSC) injury claims were recorded, with a mean 37.9 injury claims per year. The mean cost per year for the study period was $NZ196,514 with half of the injury claims occurring in New Zealand Māori. Concussion / brain injuries accounted for 3.8% of total female MSC injury claims but accounted for 5.4% of female injury costs ($NZ84,399) with the highest mean cost per claim ($NZ7,033). The lower limb accounted for 65% of the total female injury claims and 58.7% of total injury costs ($NZ922,296). Compared with other studies in rugby league injuries, it appears that females incur substantially fewer injuries (5.7%) than males (94.3%). In addition, the frequency and cost proportion for lower limb injuries was lower in male than in female rugby league players (42.4% of the injury claims and 31.5% of the total injury claim costs for the lower limb).

Comment: Interesting that women league players are less likely to report injuries than male league players. And although the researchers state that 'half of injury claims occur in NZ Māori', they haven't provided a demographic profile of women league players. I'd estimate more than half of players are Māori and therefore are we in fact seeing lower than anticipated claims for Māori women league players?

Reference: Br J Sports Med. 2009 Oct 21. [Epub ahead of print]

http://tinyurl.com/yz2zsrd

I attended the RNZCGP's Quality Symposium in February and really enjoyed these two speakers in particular. Professor Asher's comprehensive analysis on the state of children's health in Aotearoa was excellent. Some of you may have seen the follow-up story on Te Kaea the following week in which I was interviewed – although my son, Te Rangiura, was the real star according to his nana!

Child health – children are the future. Why are outcomes for NZ children among the worst in the OECD and what can be done?

Authors: Asher I

Summary: Prof. Asher details the social injustice in New Zealand that is robbing children of good health. She lists three main concerns that jeopardise the health of our children: dependent children under 18 years constitute the largest proportion (28%) of New Zealanders by age group living in poverty, the serious diseases associated with household crowding and low housing quality, and their poor access to primary health care. Prof. Asher details actions to improve child health and suggests how these can be implemented nationwide.

Reference: RNZCGP Quality Symposium, 12 February 2010.

http://tinyurl.com/yhxuewd

And, given the recent attention to the role of Integrated Family Health Centres in primary health care, I thought readers may be interested to hear about the UK experience. The key issues identified when developing their version of an IFHC, the Polyclinic, could also assist similar projects here in Aotearoa. For me, these were having strong leadership (clinical and community), wrapping services around clients/whānau, maximising IT opportunities and ensuring transport links (located near train/bus routes and adequate car parking).

The future of primary care: what role might polyclinics play? The risks and opportunities

Authors: Imison C

Summary: Dr Imison described how UK polyclinics deliver integrated care and how these polyclinics are shifting care from hospital to community-based, front-line settings, to deliver integrated and more personalised care in an area of technological change and increased costs. As detailed by Dr Imison, the polyclinic model integrates clinical and managerial leadership across primary care settings to enable care to be provided closer to patients. People with long-term conditions benefit from care integrated through rapid referral and sharing of expertise between teams.

Reference: RNZCGP Quality Symposium, 12 February 2010.

http://tinyurl.com/yfrcl6p

General Practice funding to improve provision of adolescent primary sexual health care in New Zealand: results from an observational intervention

Authors: Morgan J & Haar J

Summary: The impact of the introduction in 2003 and 2004 of free general practice (GP) sexual health visits for registered adolescents (<25-year-olds) living in rural and lower socioeconomic areas in New Zealand was analysed in this report, using data from 20 Waikato-based practices enrolled in the scheme. The data were linked to laboratory testing for *Chlamydia trachomatis* from January 2003 to December 2005. Registered population data Twenty-nine practices without additional funding served as controls. Chlamydia testing among <25 year olds at the intervention practices increased over time, in contrast to non-intervention practices, with coverage of females aged 18–24 years within the intervention increasing from 13.9% in 2003 to 16.8% in 2005. Intervention practices had significantly higher test positivity rates than non-intervention practices (8.7% vs 5.9) with increases in test positivity, from 7.7% in 2003 to 10% in 2005, relating mainly to increases in positive tests among females aged <25 years.

Comment: Targeting practices with 'high need' populations to provide free GP sexual health visits led to improved access to services for young people; there is also the potential for wider benefits such as engaging tai tamariki and young adults in other health promotion activities such as cervical cancer screening and smoking cessation. I think the area of 'sexual health' is one in which there continues to be major issues with accuracy of ethnicity data. A feasibility study is under way in the Bay of Plenty that I hope will shed further light on this.

Reference: Sex Health. 2009;6(3):203-7.

http://www.publish.csiro.au/nid/164/paper/SH09012.htm

Proteinuria, chronic kidney disease, and the effect of an angiotensin receptor blocker in addition to an angiotensin-converting enzyme inhibitor in patients with moderate to severe heart failure

Authors: Anand IS et al

Summary: These researchers assessed the safety and efficacy of valsartan in the 5010 heart failure (HF) patients with renal dysfunction participating in the Valsartan in Heart Failure Trial given valsartan or placebo. At baseline, chronic kidney disease (CKD; estimated glomerular filtration rate (eGFR) <60 mL/min/$1.73m^2$) was found in 58% and dipstick-positive proteinuria in 8% of patients. Dipstick-positive proteinuria was independently associated with mortality (HR 1.28; p=0.05) and first morbid event (HR 1.28; p=0.01). The increased risk of death associated with dipstick-positive proteinuria was similar for those with and without CKD, as was the hazard for first morbid event. Valsartan reduced eGFR compared with placebo to a similar extent (p=0.52) in those with CKD (mean reduction –3.6 mL/min/$1.73m^2$) and those without CKD (mean reduction –4.0 mL/min/$1.73m^2$) and by –3.8 mL/min/1.73/m^2 in both groups combined. The beneficial effect of valsartan on first morbid events was similar in those with and without CKD (HR 0.86 vs HR 0.91; p=0.23) and was significant in those with CKD. The effect of valsartan on mortality did not differ between patients with and without CKD.

Comment: Practitioners may withhold treatment in order to ‘do no harm’. However, as this study shows, what we think is not always backed by the evidence. Given the high rates of renal disease and heart failure for Māori, the addition of an angiotensin II receptor antagonist (more commonly called an “ARB”, which stands for angiotensin receptor blocker) to ACE inhibitors may be appropriate.

Reference: Circulation. 2009;120(16):1577-84.

http://tinyurl.com/yhqft7c

Adherence to antihypertensive medications and cardiovascular morbidity among newly diagnosed hypertensive patients

Authors: Mazzaglia G et al

Summary: Predictors of adherence to antihypertensive treatment and the association of adherence with acute cardiovascular (CV) events were explored in data from 18,806 newly diagnosed hypertensive Italians aged ≥35 years during the years 2000 to 2001. They were initially free of CV diseases. At baseline (i.e., 6 months after index diagnosis), 8.1%, 40.5%, and 51.4% of patients were classified as having high (≥80% of medication days), intermediate (40%–79% of days), and low (≤40% of days) adherence levels, respectively. Factors significantly associated with high adherence to antihypertensive treatment included multiple drug treatment, dyslipidaemia, diabetes mellitus, obesity, and antihypertensive combination therapy. Compared with their low-adherence counterparts, only high adherers reported a significantly decreased risk of acute cardiovascular events (HR 0.62; p=0.032).

Comment: “Drugs don’t work in patients who don’t take them” said Dr C. Everett Koop, M.D. Adherence to (or compliance with) a medication regimen is generally defined as the extent to which patients take medications as prescribed by their health care providers. The word “adherence” is preferred by many because “compliance” suggests that the patient is passively following the doctor’s orders. However, both terms are imperfect and any treatment plan should be based on a therapeutic alliance between the patient and the prescriber. Barriers to adherence include cost, side effects, inadequate information or limited understanding about the treatment (such as health literacy). Health providers must work with clients to address these issues in order for the ‘drugs to work’!

Reference: Circulation. 2009;120(16):1598-1605.

http://circ.ahajournals.org/cgi/content/abstract/120/16/1598

Kōrero Mārama: Health Literacy and Māori – Results from the 2006 Adult Literacy and Life Skills Survey

Authors: Ministry of Health

Summary: This report describes the health literacy skills of Māori compared to non-Māori, using data sourced from the OECD 2006 Adult Literacy and Lifeskills Survey. Health literacy is defined as the ability to obtain, process, and understand basic health information and services in order to make informed and appropriate health decisions. Māori have poorer health literacy skills compared to non-Māori across all of the measured variables. A total of 80% of Māori males and 75% of Māori females were identified with poor health literacy skills.

Comment: As alluded to in the previous study and comments, the area of health literacy is increasingly recognised as an important enabler (or barrier) to good health, well being and self determination. Importantly, it is the responsibility of service providers to assess health literacy levels. Interventions may be more difficult given the dearth of published evidence, particularly for Māori and other Indigenous peoples. Dr Sue Crengle and other Indigenous health researchers from Canada and Australia will be trialling an ‘Indigenous health literacy intervention’ designed not only for clients but their also whānau/carers and service providers. I’ll continue to keep readers informed.

Reference: Ministry of Health. 2010.* Kōrero Mārama: Health Literacy and Māori. *Wellington: Ministry of Health.

http://www.maorihealth.govt.nz/moh.nsf/indexmh/korero-marama-health-literacy-maori-feb2010