

Māori Health Review

Making Education Easy

Issue 10 – 2007

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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. 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.

Stay well, regards

Matire

Dr Matire Harwood

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Meningococcal B: tell me everything you know and everything you don't know. New Zealanders' decision-making regarding an immunisation programme

Authors: Watson PB et al

Summary: This qualitative analysis describes parents' decision-making process and the factors influencing decisions regarding children's participation in the MeNZB™ immunisation programme. Semi-structured interviews were conducted with 21 parents, 10 of whom had consented to immunisation, 10 who had not, and 1 who chose to immunise only 1 of their 2 children. Despite different outcomes, the parents were influenced by similar factors and they followed similar decision-making processes consisting of four non-linear phases; a gut reaction, a trigger, reconnaissance, and risk analysis. Most parents expressed a degree of uncertainty about their decision. "Parents' generally negative view of official information provided in the MeNZB immunisation programme suggest that communication strategies may require rethinking for future programmes", conclude the authors.

Comment: A simple and focused study that sought the parent experience for child immunisations. Interestingly, both groups of parents felt uncertain in their choice to immunize or not, suggesting that it is not a decision made lightly. Clear, concise information presented in a balanced manner is required.

Reference: *N Z Med J.* 2007;120(1263):U2751

<http://www.nzma.org.nz/journal/120-1263/2751/>

The 2008 Screening Symposium will look at current screening trends, and what the future may hold. It's a 'must attend' for anyone who works in screening or in an area affected by screening, or who has an interest in the issue.

Important Dates:

Symposium
14-15 April 2008. Te Papa Museum, Wellington.

Deadline for Abstracts
16 December 2007.

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The accuracy of ethnicity data in primary care

Authors: Bramley D and Latimer S

Summary: This study investigated the accuracy of Primary Health Organisation (PHO) register ethnicity data held within the Waitemata district of Auckland, New Zealand. Ethnicity data of children aged 5–15 years on the National Immunisation Register (NIR) were compared to ethnicity data for those children on the PHO register. NIR data were collected from parents or guardians via a protocol-based informed consent process in the Meningococcal B Immunisation Campaign. Of children recorded as Māori on the NIR, 62.9% were recorded as Māori on the PHO register, 23.3% as European and 9.6% as Unknown. Of children recorded as Pacific on the PHO register, 77.2% were recorded as Pacific on the NIR, 9.4% as European, and 6.2% as Unknown. Of children recorded as Asian on the NIR, 81.4% were recorded as Asian on the PHO register, 9.9% as Unknown and 6.0% as European. Of children recorded as European on the NIR, 83.2% were recorded as European on the PHO register and 14.4% as Unknown. These study results indicate that a standardised, systematic and appropriate sector-wide approach is needed for ethnicity data collection, conclude the authors.

Comment: As the authors ask; how can we monitor the quality of primary health care including inequalities, trends over time, and the impacts of health policy on reducing inequalities, without accurate ethnicity data? Similar research to check the quality of ethnicity data at other DHBs is encouraged.

Reference: *N Z Med J.* 2007;120(1264): U2779

<http://www.nzma.org.nz/journal/120-1264/2779/>



Independent Spirometry Educational Series for NZ GPs – reviewed by Dr David Robiony-Rogers

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Effect of urgent treatment of transient ischaemic attack and minor stroke on early recurrent stroke (EXPRESS study): a prospective population-based sequential comparison

Authors: Rothwell PM et al

Summary: This investigation assessed the effect of urgent assessment and early initiation of existing treatments on the risk of early recurrent stroke in patients presenting with a transient ischaemic attack (TIA) or minor stroke. The investigators conducted a prospective before (phase 1: April 1, 2002, to Sept 30, 2004) versus after (phase 2: Oct 1, 2004, to March 31, 2007) study of the effect on process of care and outcome of more urgent assessment and immediate treatment in clinic, rather than subsequent initiation in primary care, in all patients with TIA or minor stroke not admitted direct to hospital. The study was nested within a rigorous population-based incidence study of all TIA and stroke (Oxford Vascular Study; OXVASC), with identical methods of case ascertainment, investigation, and follow-up for both phases. Of 1278 OXVASC patients presenting with TIA or stroke (634 in phase 1 and 644 in phase 2), 607 were referred or presented direct to hospital, 620 were referred for outpatient assessment (591 [95%] to the study clinic), and 51 were not referred to secondary care. The median delay to assessment in the study clinic was reduced from 3 days in phase 1 to >1 day in phase 2, and median delay to first prescription of treatment decreased from 20 days to 1 day. The 90-day risk of recurrent stroke in the patients referred to the study clinic was significantly reduced from 10.3% in phase 1 to 2.1% in phase 2. The reduction in risk was not related to age or sex, and early treatment was not associated with an increased risk of intracerebral haemorrhage or other bleeding.

Comment: An important finding as it provides strong evidence that:

1. Specialist stroke clinic for management of minor stroke in the outpatient setting is effective (reduced risk for stroke, no increase in adverse events)
2. Organised stroke care (defined in the NZ Stroke Guidelines as timely and coordinated care with stroke expertise) including an outpatient clinic is critical
3. The care pathway or process of care also improves (reduced time to see specialist, reduced time for medical intervention) with a change in service delivery structure.

DHBs must apply the findings of such studies in order to deliver 'best practice' care.

Reference: *Lancet.* 2007;370:1432-42

[http://dx.doi.org/10.1016/S0140-6736\(07\)61448-2](http://dx.doi.org/10.1016/S0140-6736(07)61448-2)

Spirometry can be done in family physicians' offices and alters clinical decisions in management of asthma and COPD

Authors: Yawn BP et al

Summary: This study sought to determine the technical adequacy of spirometry results, concordance between family physician and pulmonary expert interpretations of spirometry test results, and changes in asthma and chronic obstructive pulmonary disease (COPD) management following spirometry testing in primary care, using outcomes from 368 spirometry tests completed over a 6-month period. These tests involved 382 patients with asthma and COPD and staff from 12 family medicine practices across the US. A total of 71% of the tests were technically adequate for interpretation. Concordance between family physician and pulmonary expert interpretations of test results was observed in 76% of tests; concordance was higher for patients with asthma than for those with COPD. Changes in management occurred in 48% of patients following spirometry testing, including 107 medication changes (>85% concordant with guideline recommendations) and 102 nonpharmacological changes.

Comment: Asthma and COPD are significant health issues for Māori and therefore some practices, on reading this paper, may want to undertake spirometry on site. For such providers, there are a number of options. At our practice, we had a GP with respiratory training undertake the spirometry, interpret results and discuss management with the referring GP. Others have a respiratory worker (normally nurse or physiotherapist) visit, particularly during winter, and run spirometry clinics. Finally, formal or informal training can be provided at regional hospitals.

Reference: *Chest.* 2007;132:1162-8

<http://dx.doi.org/10.1378/chest.06-2722>

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School-based health centers: improving access and quality of care for low-income adolescents

Authors: Allison MA et al

Summary: Visit rates, emergency care use, and markers of quality of care were compared between adolescents who use school-based health centres and those who use other community centres within a safety-net health care system for low-income and uninsured patients. Data were collated from Denver Health electronic medical charts, the Denver Health immunization registry, and Denver Public Schools enrolment data for the period from August 1, 2002, to July 31, 2003. The cohort comprised all 14- to 17-year-old Denver Public Schools high school enrollees who were active Denver Health patients and were either uninsured or insured by Medicaid or the State Children's Health Insurance Program. School-based health centre users (n=790) were less likely than other users (n=925) to be insured (37% vs 73%), but were more likely to have made ≥ 3 primary care visits (52% vs 34%), less likely to have used emergency care (17% vs 34%), and more likely to have received a health maintenance visit (47% vs 33%), an influenza vaccine (45% vs 18%), a tetanus booster (33% vs 21%), and a hepatitis B vaccine (46% vs 20%). The authors conclude that school-based health centres augment access to health care for underserved adolescents compared with traditional outpatient care sites.

Comment: Statistics show that adolescent health care has not seen the same level of improvement in service and reduction in morbidity as other age groups within New Zealand. The Youth 2000 National Secondary Survey highlighted that access, affordability and confidentiality were critical factors to adolescents seeking health care. For school health clinics to succeed, a partnership between health and education is required. PHOs are ideally placed to manage the health of taitamariki including onsite medical consultations, access to GPs with special interests such as sexual or mental health and easy access to other health services. I found a fantastic website with great information about school health clinics (where, when, how to access) as an example of what can be done - <http://www.trippin.co.nz/nurse.html>.

Reference: *Pediatrics*. 2007;120:e887-94
<http://dx.doi.org/10.1542/peds.2006-2314>

Improving asthma-related health outcomes among low-income, multiethnic, school-aged children: results of a demonstration project that combined continuous quality improvement and community health worker strategies

Authors: Fox P et al

Summary: This study reports findings from a demonstration project using continuous quality improvement and community health workers, designed to improve asthma-related health outcomes among low-income, multiethnic, school-aged children. The project involved 7 community clinics treating approximately 3000 children 5–18 years of age with asthma. Cross-sectional chart reviews of 560 patients at baseline and 24 months showed that care-process changes resulted in clinic-wide improvements in the documentation of asthma severity, review of action plans, health services use, and asthma symptoms. In a subset of 405 patients with either moderate or severe persistent asthma or poorly controlled asthma, follow-up revealed fewer acute visits, emergency department visits, hospitalisations, frequent daytime and night-time symptoms, and missed school days, compared with baseline. According to a linear regression analysis, closer adherence to the demonstration model was directly associated with better outcomes.

Comment: For me the study confirms that best practice (defined here as the clinic's adherence to asthma guidelines including asthma education, provision of action plans and improved documentation) benefits all.

Reference: *Pediatrics*. 2007;120:e902-e11
<http://dx.doi.org/10.1542/peds.2006-1805>

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

Smoking in movies and increased smoking among young adults

Authors: Song AV et al

Summary: This US study assessed whether exposure to on-screen smoking in movies is associated with young adult smoking behaviour. A sample of 1,528 young adults aged 18–25 years took part through a national web-based cross-sectional survey in 2005. Findings revealed a direct effect between exposure and current smoking. Compared with young adults who saw little smoking in movies, young adults who saw the most smoking on screen were 77% more likely to have smoked at least once in the past 30 days (a measure of smoking initiation) and were 86% more likely to be regular established smokers (defined as having smoked ≥ 100 cigarettes and currently smoking). Two factors mediated the association between exposure to film smoking and established smoking: positive expectations about smoking and exposure to friends and relatives who smoke.

Comment: This is the first study to show that smoking among young adults is associated with exposure to smoking scenes on screen. Ages 18–25 are critical years when one-third of smokers start and others who began smoking as adolescents either stop smoking or become regular smokers. Although the effect in young adults is not as large as for adolescents, it is clear that smoking scenes in movies is a risk factor for smoking initiation in young adults.

Reference: *Am J Prev Med*. 2007;33:396-403
<http://www.ajpm-online.net/article/PIIS0749379707004709/abstract>

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Hauora: Māori Standards of Health IV. A study of the years 2000–2005

The Hauora: Māori Standards of Health series provides data and commentary on inequalities in health status, health care, and outcomes between Māori and non-Māori. The fourth edition, covering the years 2000–2005, is now available, published by Te Rōpū Rangahau Hauora a Eru Pōmare. It includes data on the Māori population, social and economic indicators, hospitalisations, mortality, cancer and mental health. It also contains chapters by invited authors on a range of health issues, including CVD, diabetes, respiratory disease, oral health, disability, sleep problems, occupational safety and health, health in prisons, and the National Primary Medical Care Survey.

The book can be downloaded from www.hauora.maori.nz or can be ordered in hard copy by emailing: moh@wickcliffe.co.nz or calling (04) 496 2277 quoting HP4497.

Ethnic differences in diabetic retinopathy

Authors: Simmons D et al

Summary: This study investigated rates of diabetic retinopathy in 458 (67.5% of eligible) randomly selected household survey participants with known diabetes (168 Europeans, 144 Māori, 149 Pacifica people). Type 2 diabetes was associated with significantly higher rates of moderate or more severe retinopathy in Māori and Pacifica people, compared with Europeans (12.9% and 15.8% vs 4.0%, respectively). No such ethnic differences were seen for overall rates of retinopathy and macular disease. Pacifica ethnicity was associated with a significantly higher rate of cataracts (36.6% vs 19.3% for Europeans and 16.4% for Māori). After adjusting for diabetes duration and ethnicity, patients with type 1 diabetes were over 5 times more likely to develop moderate or more severe retinopathy. While Māori and Pacifica people with type 2 diabetes were more hyperglycaemic, with higher systolic and lower diastolic blood pressure, logistic regression analysis revealed that moderate or more severe retinopathy was associated with diabetes duration, insulin therapy, ethnicity and the extent of renal disease, but not glycaemia. Long-standing hyperglycaemia may explain the higher rates of moderate and more severe retinopathy in Māori and Pacifica people than in Europeans, suggest the authors.

Comment: Diabetes can be managed through nutrition, exercise and sometimes medication. Primary health and specialist diabetes services play important roles in helping people/whānau manage diabetes. When care is inadequate, hyperglycaemia (raised blood sugar) is sustained and over a long period can cause microvascular or small blood vessel disease. Arteries are affected in the eyes (causing retinopathy and sometimes blindness), kidneys (leading to renal failure requiring dialysis or transplant) and cardiovascular system (strokes and heart attacks). High quality diabetes care, including prevention, is a priority for Māori in order to reduce risk of diabetes, ensure normoglycaemia for people with diabetes and therefore improve outcomes/prevent complications.

Reference: *Diabet Med.* 2007;24:1093-8
<http://dx.doi.org/10.1111/j.1464-5491.2007.02227.x>

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Abstracts from INIHKD

The following two abstracts are from posters presented at the recent International Network for Indigenous Health Knowledge and Development (INIHKD) conference, held in Rotorua. These abstracts are expected to become available soon through the INIHKD website - <http://www.inihkd.org/>. Meantime, the study authors may be contacted directly.

Pukapuka Hauora: Māori parents experience of managing a child with asthma (theme development pilot)

Authors: Jones B & Ingham T. Wellington School of Medicine and Health Sciences, University of Otago, Wellington, NZ

Summary: This pilot aimed to uncover themes experienced by parents and whānau managing their children's asthma and interacting with healthcare providers, for informing the interview structure for a planned 2-year in-depth qualitative assessment. The main project will use an Interpretative Phenomenological Approach to acknowledge the social and cultural context of participants and will use a semi-structured interview based on the predefined themes identified in the pilot. A grounded-theory approach, using a Kaupapa Māori perspective which is culturally, spiritually and tribally based, was used in the pilot and in-depth interviews were conducted with parents identified through a Māori asthma provider. The interviews were taped and transcribed and constant comparative analysis was used to develop themes. Those that emerged included difficulties recognising asthma symptoms and identifying triggers, asthma care at school, appropriate asthma education, discontinuity of healthcare provision and economic issues. The authors hope that their project will enable the 'voices' of whānau to be heard and thereby transform how systems respond to, engage with, and treat Māori.

Comment: A great example of how qualitative research methods are used to provide context and foundation to further study.

Reference: *Whānau – Kin Networks: Research. Poster 45. Presented on Tuesday 16 October, 11.00am – 12.00pm.*

Manaaki Manawa: A cardiac rehabilitation developed by Māori for Māori

Authors: Henwood WA, Mahanga Q, & Rakena A. Whariki Research Roopu, Massey University, Auckland

Summary: This poster presents key findings from interviews with clients of Manaaki Manawa, a cardiac rehabilitation programme developed by Māori for Māori. Notably, its components have been influenced by earlier research findings demonstrating the poor uptake and completion rates of Māori in mainstream cardiac programmes. A fundamental part of the initiative implemented by Māori Health Providers in Te Tai Tokerau (Northland, New Zealand) is its formative and process evaluation, which has established relationships amongst all the parties. The client interviews reveal promising indicators of improved 'wellness' for participants. However, one of the tensions identified is how exactly 'improved health' or 'wellness' can be measured in a meaningful way, from both a clinical perspective and that of the client participating in the cardiac rehabilitation programme. The key findings from the interviews illustrate some important factors that have led to positive health and wellbeing changes for clients; the supportive home-based whānau-orientated approach, the wairua of the cardiac rehabilitation nurse, the tailored and flexible nature of the programme and a practical understanding of their health condition and medication issues. The cardiac rehabilitation nurses have observed how their clients' clinical results have been positively influenced by 'feeling more confident and in control of their lives'.

Comment: A programme developed to meet the cardiac rehabilitation needs of Māori living in Te Tai Tokerau. Internationally, cardiac rehabilitation has been shown to improve quality of life for participants. Yet there has been little research about it here in Aotearoa. I understand that THMM and NHF will undertake an audit of all cardiac rehab programmes and differences in process of care and outcomes by ethnicity will be reported.

Reference: *Whānau – Kin Networks: Research. Poster 47. Presented on Tuesday 16 October, 11.00am – 12.00pm.*

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