

# Māori Health Review

Making Education Easy

Issue 33 – 2011

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

*Research Review publications are intended for New Zealand health professionals.*

## Tēnā koutou katoa

Tēnā koutou, tēnā koutou, tēnā tatou katoa.  
Naumai, haere mai ki tenei Tirohanga hou Hauora Māori.

## Greetings

Welcome to this issue of the Māori Health Research Review, and warm greetings for the Matariki season. Congratulations to the successful applicants of the recent HRC funding round. We have some fantastic Māori health research currently in Aotearoa and I look forward to seeing outcomes from the fantastic projects that are about to commence.

## Matire

Dr Matire Harwood  
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## Racism as a determinant of social and emotional wellbeing for Aboriginal Australian youth

**Authors:** Priest NC et al

**Summary:** In this exploration into the associations between self-reported racism and health and wellbeing outcomes for young Aboriginal Australians, 345 Aboriginal Australians aged 16–20 years completed a questionnaire validated as culturally appropriate that sought to uncover any evidence on the effects of racism upon health outcomes. All participants had been recruited at birth between 1987 and 1990 in the prospective Aboriginal Birth Cohort Study and were followed-up between 2006 and 2008. A third of the subjects (32%) reported self-reported racism. Significant associations were observed between racism and anxiety (odds ratio [OR], 2.18), depression (OR, 2.16), suicide risk (OR, 2.32) and poor overall mental health (OR, 3.35). No significant associations were found between self-reported racism and resilience or any anthropometric measures.

**Comment:** More evidence showing the effects of racism on health outcomes – unfortunately in young people. Some readers may also be interested by the findings on 'resilience'.

**Reference:** *Med J Aust.* 2011;194(10):546-50.

[http://www.mja.com.au/public/issues/194\\_10\\_160511/pri10947\\_fm.html](http://www.mja.com.au/public/issues/194_10_160511/pri10947_fm.html)

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## The statistical profile Māori smoking and tobacco use 2011 (the Profile)

The purpose of the Profile is to provide a summary of the latest information on Māori smoking and tobacco use compared to that of non-Māori. The Profile uses findings from the 2009 New Zealand Tobacco Use Survey. It presents data on daily smoking rates over time, current smoking rates by age group, the type of tobacco smoked, second-hand smoke exposure, the smoking habits of young Māori smokers, quitting, and use of Quitline services.



For more information, please go to <http://www.maorihealth.govt.nz>

## A Kaupapa Māori approach to a community cohort study of heart disease in New Zealand

**Authors:** Pitama S et al

**Summary:** This paper reports on the processes and protocols that were developed in the design and implementation of the Hauora Manawa Project, a cohort study of heart disease in New Zealand. The study applied a Kaupapa Māori methodology to gain tribal and health community engagement, design the project and randomly select participants from territorial electoral rolls. Time invested in gaining tribal and health community engagement assisted in the development and design of clear protocols and processes for the study. Response rates for the three study cohorts of rural Māori, urban Māori and urban non-Māori were 57.6%, 48.3% and 57.2%, respectively. Co-operation rates (participation among those with whom contact was established) were 74.7%, 66.6% and 71.4%. The study authors comment that these co-operation rates highlight the acceptability of this research project to the participants and demonstrate the strength of Kaupapa Māori methodologies in engaging Māori participants and community.

**Comment:** Very useful and practical information and a great reference for papers or funding applications. Also expect to see more innovative ways of incorporating Kaupapa Māori methodologies into advancing technology (e.g. Facebook pages for studies) in order to improve sampling and follow-up.

**Reference:** *Aust N Z J Public Health*. 2011;35(3):249-55.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1753-6405.2011.00702.x/abstract>

## Do Māori and Pacific Islander men present with more advanced prostate cancer than European New Zealand men? An analysis of 486 men undergoing biopsy in Auckland

**Authors:** Pokorny MR, Scott DJ.

**Summary:** This retrospective audit analysed data from the Auckland Hospital Urology Service database of all men presenting there for a first prostate biopsy in 2005 and 2006. The study aim was to determine whether Māori and Pacific Islander men in Auckland present with more advanced prostate cancer at diagnosis than New Zealand European or European men. Ethnicity was coded from self-identification codes on hospital databases. No appreciable difference was observed when Māori and Pacific Islander men were compared with European men for median PSA level (13.30 vs 12.55 ng/mL); median Gleason score (7 and 7), mean Gleason score (7.0 vs 6.9) or the proportion of Gleason Score 7 or 8–10. Likewise, the rates of metastatic disease did not differ at presentation (11.5% vs 7.8%). However, there appeared to be a significant difference in the proportion of Māori and Pacific Islanders presenting with palpable disease compared with European men (67.2% vs 53.3%;  $p=0.042$ ). The crude population biopsy rate per 100,000 was similar for Māori and Pacific Islander and European men (560 vs 547).

**Comment:** An important study given the significant inequalities in survival rates for prostate cancer between Māori and non-Māori. Interestingly, whilst 'late presentation' is considered to be a major contributing factor to survival disparities between Māori and non-Māori, these findings contest its occurrence. A review of treatment rates by ethnicity is required.

**Reference:** *BJU Int*. 2011;107 Suppl 3:27-32.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1464-410X.2010.09988.x/abstract>

## Can we reduce health inequalities? An analysis of the English strategy (1997–2010)

**Author:** Mackenbach JP

**Summary:** This paper sought to determine whether England's systematic policy to reduce socioeconomic inequalities in health has been successful since the strategy was introduced in 1997, and what lessons can be learnt. The review of evidence included documents, an analysis of entry-points chosen, specific policies chosen, implementation of these policies, changes in intermediate outcomes, and changes in final health outcomes. The paper reports that there have been some partial successes, but the strategy has failed to reach its own targets of a 10% reduction in inequalities in life expectancy and infant mortality. This is explained as being due to the policy failing to address the most relevant entry-points, failing to use effective policies and not delivering the strategy on a scale large enough to achieve population-wide impacts. The study author concludes that "health inequalities can only be reduced substantially if governments have a democratic mandate to make the necessary policy changes, if demonstrably effective policies can be developed, and if these policies are implemented on the scale needed to reach the overall targets".

**Comment:** As the author states, England was one of the first countries to pioneer policies aimed at 'reducing health inequalities'. This timely review of outcomes has fortunately also provided rationalisation for the limited success – such details should help to inform the necessary political changes required here.

**Reference:** *J Epidemiol Community Health*. 2011;65(7):568-75.

<http://jech.bmj.com/content/65/7/568.abstract>

## Congratulations

*to Isobel Murphy, Occupational Therapist at Kidz First Child Development Team part of Counties Manukau District Health Board, who won an MY65T Navman GPS Unit for completing our Maori Health Review subscriber survey.*

## Tatau Kura Tangata:

### Health of Older Māori Chart Book 2011

*presents a snapshot of the health of Māori aged 50 years and over in New Zealand.*

Copies can be ordered from Wickliffe [moh@wickliffe.co.nz](mailto:moh@wickliffe.co.nz) or 04 496 2277 please quote HP 5097 (Tatau Kura Tangata) or HP 5329 (Spinning Wheel). This publication is also available on the Ministry website [www.moh.govt.nz](http://www.moh.govt.nz) and the Māori health website [www.maorihealth.govt.nz](http://www.maorihealth.govt.nz)

The chart book provides a comprehensive review of Māori health data for those aged 50+, with the statistical information accessible in an easy-to-use format. The most recent data available are presented for each indicator. This chart book presents key indicators relating to the socioeconomic determinants of health, risk and protective factors for health, health status, health service utilisation, and the health system. The accompanying Overview Spinning Wheel provides selected indicators from *Tatau Kura Tangata*. This spinning wheel is an innovative way of disseminating information contained in this publication. Selected indicators are provided in an easy-to-use and compact format for DHBs, Health practitioners, iwi providers, government departments, universities, students and the general population.

For more information, please go to <http://www.maorihealth.govt.nz>

### Streptokinase antibodies in patients presenting with acute coronary syndrome in three rural New Zealand populations

Authors: Nixon G et al

Summary: This paper states that New Zealand Māori have some of the highest rates of Group A streptococcal infection (GAS) in the world. Since GAS elevates titres of anti-streptokinase (SK) neutralising antibodies, GAS may induce resistance to SK. The study measured anti-SK titres in 180 patients presenting with symptoms consistent with an acute coronary syndrome to three New Zealand rural hospitals, selected because they provide care for patients from communities with different socioeconomic and ethnic mixes (Māori proportions were between 6% and 67%). Compared with the community with the lowest proportion of Māori, patients in the community with the highest proportion of Māori had mean anti-SK titres that were 2.8 times higher (p=0.05) and they were 2.5 times more likely to have a high anti-SK titre (33% vs 13% p=0.035).

Comment: There appears to be an increasing focus in research and clinical fields on the role of ethnicity in pharmaceutical treatment. My concern is that such 'literature' may influence clinical decisions to the detriment of Māori health outcomes (for example, SK is not offered to Māori presenting with ST elevation MI because they MAY have higher anti-SK titre). As the researchers suggest, the point is that evidence-based best practice should be made available to all citizens. Therefore, firstly we should strive to treat GAS asap and reduce the incidence of SK resistance. And if SK is not clinically appropriate, alternatives (such as PCI or CABG) must be offered to ensure best and equitable outcomes.

Reference: J Clin Pathol. 2011;64(5):426-9.

http://jcp.bmj.com/content/64/5/426.abstract

### Organochlorines and heavy metals in wild caught food as a potential human health risk to the indigenous Māori population of South Canterbury, New Zealand

Authors: Stewart M et al

Summary: Selected bioaccumulative contaminants were investigated in wild kai (food) of cultural, recreational and economic importance to the indigenous Māori of South Canterbury, New Zealand. Contaminants of concern included dieldrin, ΣPCBs, p,p'-DDE, mercury and arsenic, levels of which were analysed in important kai species including eel (Anguilla sp.), brown trout (Salmo trutta), black flounder (Rhombosolea retiaria) and watercress (Nasturtium officinale) from important harvesting sites in the region of South Canterbury. Calculations revealed a lifetime excess cancer risk was associated with consumption of eels, trout and flounder. In another analysis, a non-cancer chronic health risk was associated with consumption of eels and trout. A cumulative lifetime cancer risk assessment demonstrated a potential health risk in consuming some species, even at low consumption rates. The study authors recommend that dietary consumption limits be established for harvest sites within the study region.

Comment: An excellent article demonstrating the need for quality research in papa kainga, Māori communities and sites of engagement with the environment such as fishing or harvesting sites. The impact of environmental contamination is far reaching, affecting the wellbeing of our ecosystems, our kai, traditional knowledge and of course health outcomes.

Reference: Sci Total Environ. 2011;409(11):2029-39.

http://www.sciencedirect.com/science/article/pii/S0048969711002014

### Risk and protective factors for suicide attempt among Indigenous Māori youth in New Zealand: the role of family connection

Authors: Clark TC et al

Summary: These researchers sought to describe risk and protective factors associated with a suicide attempt for Māori youth and also explore whether family connection moderates the relationship between depressive symptoms and suicide attempts for Māori youth. The study cohort comprised 1702 Māori young people aged 12–18 years from an anonymous representative national school-based survey of New Zealand (NZ) youth in 2001. In a logistic regression analysis, risk factors identified as being associated with a suicide attempt in the past year included depressive symptoms (odds ratio [OR], 4.3; p<0.0001), having a close friend or family member commit suicide (OR, 4.2; p<0.0001), being 12–15 years old (reference group: 16–18 years) (OR, 2.7; p<0.0001), having anxiety symptoms (OR, 2.3; p=0.0073), witnessing an adult hit another adult or a child in the home (OR, 1.8; p=0.001), and being uncomfortable in NZ European social surroundings (OR, 1.7; p=0.0040). While family connection was associated with fewer suicide attempts (OR, 0.9; p=0.0002), this factor failed to moderate the relationship between depressive symptoms and suicide attempt (χ2 = 2.84; p=0.09).

Comment: Given the high suicide rates in NZ, and recent 'epidemics' in some communities, this study provides a timely reminder of the 'red flags' for suicide risk. New to me was 'being uncomfortable in NZ European social settings' as a significant risk factor and one that I will need to consider when managing young Māori with depression.

Reference: Journal of Aboriginal Health. 2011;March:16-31.

http://www.naho.ca/jah/english/jah07\_01/07\_01\_02\_maori-suicide-risk.pdf

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## Cytisine's potential to be used as a traditional healing method to help Indigenous people stop smoking: a qualitative study with Māori

**Authors:** Thompson-Evans TP et al

**Summary:** These researchers explored the potential of using cytisine, a plant extract found in Golden Rain (*Cytisus laburnum* L.) and the New Zealand Kowhai (*Sophora tetraptera* L.) with a similar molecular makeup to nicotine, as a 'rongoā Māori' (traditional Māori remedy) and its attractiveness to Māori smokers compared with other cessation products. Focus groups and individual semi-structured interviews with Māori that smoked, as well as interviews with two key informants, revealed the following barriers to using cessation products: financial and effort cost; pervasive smoking among family and peers; environments permissive of smoking; and perceived cultural inappropriateness of treatments. Participants were very interested in cytisine, supported the idea that it would be acceptable to package it as a rongoā Māori, and all wanted to use it. Named appropriately, packaged and promoted as a Māori cessation product, participants thought cytisine would contribute to the restoration of Māori identity and traditional beliefs and practices in addition to reducing smoking.

**Comment:** I welcome studies such as this where the researchers are looking 'outside of the box' to tackle the issue of smoking cessation with Maori. I guess we should watch this space.

**Reference:** *Nicotine Tob Res.* 2011;13(5):353-60.

<http://ntr.oxfordjournals.org/content/13/5/353.abstract>

## Sociodemographic differences in prevalence of diagnosed coronary heart disease in New Zealand estimated from linked national health records

**Authors:** Thornley S et al

**Summary:** Linked health records, comprising hospital treatment for CHD, dispensing of selected anti-anginal drugs and mortality were used in this study to estimate sociodemographic differences in the prevalence of coronary heart disease (CHD) in New Zealand in December 2008. Among a "health contact" population of adults ( $\geq 15$  years), about one in 20 (6.5% of men and 4.1% of women) had indicators of a past diagnosis or treatment for CHD or both. Prevalence differed substantially by gender, ethnic group and socioeconomic status. For example, among New Zealanders aged 35–74 years, Indian men had the highest age-adjusted prevalence (7.78%), almost double the prevalence of males in the 'Other' ethnic group (mainly New Zealand European). Among women, Māori had the highest adjusted prevalence (4.03%), just over twice that of 'Others'.

**Comment:** CVD risk is often considered an issue for males (as seen in many social marketing campaigns). However, the results send a clear message that prevention and management of CVD risk in Māori women is just as vital. As the editorial<sup>1</sup> suggests, a population-wide approach, in addition to individual risk assessment, is required to reduce CVD risk. Smoking cessation is probably a good place to start, given the high rates amongst Māori women.

1. Stewart RAH. The challenge of reducing socioeconomic and ethnic differences in cardiovascular disease. *N Z Med J.* Available at: <http://www.nzma.org.nz/journal/124-1334/4667/>.

**Reference:** *N Z Med J.* 2011;124(1334).

<http://www.nzma.org.nz/journal/abstract.php?id=4660>

## Achieving equitable outcomes for Māori women with cervical cancer in New Zealand: health provider views

**Authors:** McLeod M et al

**Summary:** This paper presents an analysis of key themes identified from transcripts of focus groups undertaken with three health provider groups in different regions of New Zealand working across the range of cervical cancer services. The focus groups sought to uncover health provider views on changing survival disparities between Māori and non-Māori women, the management of cervical cancer in New Zealand, and achieving equitable outcomes from cervical cancer for Māori women. Providers were encouraged by improvements over time in survival disparities between Māori and non-Māori. Key themes of discussion relating to cervical cancer management included: communication and education; screening; access to treatment; pathways through care; patient factors; and system standards. Providers suggested options for further improvements in the management of cervical cancer to achieve equitable outcomes for Māori, particularly in the areas of prevention and early detection.

**Comment:** Data confirms the disparities in cervical screening rates between Māori, Pacifica and women living in deprived neighbourhoods compared with 'Others'. The options provided here to improve management, including screening, of cervical cancer, are particularly useful to someone like me working in primary care.

**Reference:** *N Z Med J.* 2011;124(1334).

<http://www.nzma.org.nz/journal/abstract.php?id=4661>

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