

Māori Health Review

Making Education Easy

Issue 20 – 2009

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Tēnā koutou, tēnā koutou, tēnā tātou 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

I will be experiencing the health system from the 'other side' in June and not available for the next issue. However Dr Rhys Jones (Ngati Kahungungu) has agreed to take over the role and will be showcasing some of the exciting papers from the Tane Ora Hui. For more information about the hui please see the link - <http://www.taneora.co.nz/>

Matire

Dr Matire Harwood

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Material hardship and the physical health of school-aged children in low-income households

Authors: Yoo JP et al

Summary: Data from 1073 children aged 5–11 years whose caregivers participated in multiple waves of the Illinois Families Study were examined for the relationship between material hardship reported by low-income caregivers and caregivers' assessments of their children's overall health. Caregivers' reports of food hardship were strongly associated with their assessments of their children's health. While other sources of self-reported material hardship were also associated with caregivers' assessments of their children's health, the effects disappeared after controlling for caregiver physical health status and mental health status. Proximal measures of material hardship better explained low-income children's health than traditional socioeconomic measures. No statistically significant cumulative effects of material hardships were found besides the individual hardship effects.

Comment: When kids don't have access to more nutritious kai; when they're living in poor conditions; and when parents/caregivers can't participate in health promotional activities, children's health will suffer. Concern has been raised that measures to improve nutrition for children may be stripped back given the removal of HEHA (Health Eating, Healthy Action) from the list of health targets (2009/10). However, the Minister and Ministry of Health have stated that "All health services are important. Previous Health Targets are reported on as part of formal DHB reporting. Gains made in these areas are expected to be built on." Let's hope so.

Reference: *Am J Public Health. 2009;99(5):829-36.*

<http://www.ajph.org/cgi/content/abstract/99/5/829>



Minding the Gap

CARDIAC CARE TO MAORI AND PEOPLES OF THE SOUTH PACIFIC

COPTHORNE HOTEL, ORIENTAL BAY, WELLINGTON • THURSDAY 11 JUNE 2009

Conference details found at: www.cranz.org.nz

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a RESEARCH REVIEW publication

Socioeconomic inequality in exposure to bullying during adolescence: A comparative, cross-sectional, multilevel study in 35 countries

Authors: Due P et al

Summary: These researchers examined the socioeconomic distribution of adolescent exposure to bullying and documented the contribution of the macroeconomic environment, using data from an international survey of 162,305 students aged 11, 13, and 15 years from nationally representative samples of 5998 schools in 35 countries in Europe and North America for the 2001–2002 school year. Adolescents from families of low affluence reported higher prevalence of being victims of bullying (OR 1.13). No associations were seen between international differences in prevalence of exposure to bullying and the economic level of the country (as measured by gross national income) or the school, whereas wide disparities in affluence at a school and large economic inequality (as measured by the Gini coefficient) at the national level were linked to an increased prevalence of exposure to bullying.

Comment: The important message from this study is that bullying, and strategies to reduce it, are complex. Although the focus has been on the new forms of bullying (text and web-based) and punishing individuals, a public health approach is also required to address disparities within schools and the larger economic inequalities.

Reference: *Am J Public Health.* 2009;99(5):907-14.

<http://tinyurl.com/q79z48>

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

Perceived racial/ethnic discrimination among fifth-grade students and its association with mental health

Authors: Coker TR et al

Summary: Data were examined from 5147 fifth-grade students and their parents from public schools in 3 US metropolitan areas, in an attempt to describe the prevalence, characteristics, and mental health problems of children who experience perceived racial/ethnic discrimination. Fifteen percent of children reported perceived racial/ethnic discrimination, with 80% reporting that discrimination occurred at school. Higher proportions of Black (20%), Hispanic (15%), and other (16%) children reported perceived racial/ethnic discrimination compared with White (7%) children. Children reporting perceived racial/ethnic discrimination were more likely to have symptoms of each of the 4 mental health conditions included in the multivariate logistic regression analysis: depression, attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder. Perceived racial/ethnic discrimination and depressive symptoms was associated with depressive symptoms for Black, Hispanic, and other children but not for White children.

Comment: Aligns with the study from Dr Ricci Harris and others that was reported in the *Lancet* ([http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)68890-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68890-9/abstract)), which had similar results for Māori adults. The sheer magnitude of the problem (20% of African American children reporting racism and twice the rates of White children) and its impact on health suggest that the issue of racism can not be ignored and that interventions to address it must start early.

Reference: *Am J Public Health.* 2009;99(5):878-84

<http://www.ajph.org/cgi/content/abstract/99/5/878>

Experiences of whānau/families when injured children are admitted to hospital: a multi-ethnic qualitative study from Aotearoa/New Zealand

Authors: Arlidge B et al

Summary: These researchers sought to explore and describe the experiences of indigenous Māori and Pacific families (both minority populations) and Pākehā (New Zealand European) families when their children were admitted to hospital for an unintended injury, using a study sample of 23 children (8 Māori, 8 Pacific and 7 Pākehā). In-depth individual and group interviews undertaken with the child's whānau/family revealed that although many families praised the dedication of the staff, they also had important concerns regarding their encounters with hospitals and related health and support services. Coding of the data uncovered four main themes: (a) inadequate communication and information; (b) difficulties negotiating an environment perceived as foreign; (c) the stress of conflicting demands placed on families; and (d) issues relating to ethnicity and cultural miscommunication. Of note, many Māori and Pacific whānau/families felt particularly alienated within the hospital setting and did not appear to see themselves as being entitled to high-quality information or services.

Comment: It was interesting to read that parents were critical of the system and not individual service providers. Therefore, the problem requires a system approach that identifies ways to increase the sense of entitlement or right to health and healthcare. Some examples include a patient charter (describing in detail what you should expect from your health service) and checklist (similar to decision support tool for providers but is held by the patient/whānau). I'd also suggest that educating providers about disparities and getting them to generate possible interventions would be useful.

Reference: *Ethnicity & Health.* 2009;14(2):169-83.

<http://www.informaworld.com/smpp/content~content=a901465229~db=all~order=page>

He Ritenga Whakaro: Māori Experiences of Health Services



This research was funded by the Health Research Council, Accident Compensation Corporation and the Ministry of Health.

The research notes that while Māori have lower life expectancy, greater morbidity and higher rates of disability, they have less access to health and rehabilitation services than do non-Māori. The research sought to capture the perceptions of Māori consumers in order to contribute to a robust understanding of how the health system is or is not facilitating their access to health care.

An electronic link to this report can be found on the Māori Health website www.maorihealth.govt.nz



Inequalities in health at older ages: a longitudinal investigation of the onset of illness and survival effects in England

Authors: McMunn A et al

Summary: This study examined whether wealth gradients in the incidence of illness decline with age, and, if so, whether this decline is explained by differential mortality, in an analysis of data from the first two waves of the English Longitudinal Study of Ageing (ELSA), a large national longitudinal study of the population aged 50+ in England, who reported good health, no functional impairment, or no heart disease at baseline. Wealth inequalities in onset of illness over 2 years were examined across age groups, with and without the inclusion of mortality. Wealth predicted onset of functional impairment equally across age groups. For self-reported health and heart disease, wealth gradients in the onset of illness declined with age. Selective mortality contributed to this decline in the oldest age groups.

Comment: We have a similar picture here in Aotearoa – disparities by level of deprivation and ethnicity persist with ageing. And in fact, disparities between Māori and non-Māori with cardiovascular disease actually increase with age to a point (the difference is smaller in the over 65-year-old population because of the small number of Māori living this long but a major gap still exists). The majority of NZ's population are adults aged 25 to 45 and Pākehā. It's worth remembering too that this group are the voters and consumers and will therefore have a significant influence on societal values. We must support those considered to be on the 'margins' (non-Pākehā, children/youth, aged, disabled) as they are most likely to be disadvantaged in health status.

Reference: *Age Ageing*. 2009;38(2):181-7.

<http://tinyurl.com/qdqznu>

Socioeconomic and race/ethnic patterns in persistent infection burden among U.S. adults

Authors: Zajacova A et al

Summary: This report presents an analysis of data from the National Health and Nutrition Examination Survey III (n=19,275) for adults aged 17–90 years, in an investigation into how multiple persistent infections cluster within individuals and how this clustering varies by socioeconomic position and race/ethnicity in U.S. adults. A positive correlation was observed for seroprevalence of individual persistent infections, suggesting common factors related to exposure or susceptibility. In all multiple indicator multiple cause models, strong and significant independent predictors of infection burden in U.S. adults included education, income, and race/ethnicity.

Comment: Important that we don't look at the burden of persistent infections among disadvantaged people as 'their problem'. I can imagine some people saying 'it's because they didn't see the doctor for antibiotics' or 'it's their living conditions'. Instead, the paper provides evidence for a biological cause of health disparities that occur when there is disadvantage at the system level and therefore even further reason to ensure good quality primary care for those at risk of chronic infection (Māori, Pacifica, higher levels of deprivation).

Reference: *J Gerontol A Biol Sci Med Sci*. 2009;64(2):272-9.

<http://biomedgerontology.oxfordjournals.org/cgi/content/abstract/64A/2/272>

Routine vaccination coverage of 11 year olds, by ethnicity, through school-based vaccination in South Auckland

Authors: Loring BJ and Curtis ET

Summary: This New Zealand study analysed de-identified aggregate data from the Auckland Counties Manukau District Health Board (CMDHB) Public Health Nurses Database on the 11-year-old tetanus and polio vaccinations from 2005, to determine percentages of form return, consent and vaccination receipt by ethnicity, including relative risks for Māori compared to non-Māori students. Reasons for vaccination refusal were also analysed. Overall, 48% of Māori and 56% of non-Māori in Year 7 in CMDHB in 2005 (n=8642) were immunised through the school-based programme. Assuming that parents who stated their child had already received these vaccinations were all correct, the estimated overall coverage in this population for the recommended Year 7 tetanus vaccination was 67% (53% for Māori, and 71% for non-Māori).

Comment: As the accompanying editorial's heading stated, immunisation is an important mechanism through which NZ can improve children's health and reduce health inequalities. Other vaccination programmes (for example the MenzB campaign) with targeted interventions for Māori have been extremely successful in reducing disparity between Māori and non-Māori for vaccination rates in school-aged children and improving health status (reduced deaths/cases). Leaving a consent form with a child is not satisfactory; schools, their nurses, primary care providers have to do more to ensure that parents can provide informed consent for vaccinations.

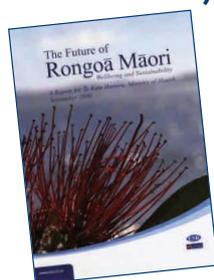
Reference: *N Z Med J*. 2009;122(1291):14-21.

<http://www.nzma.org.nz/journal/abstract.php?id=3509>

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The Future of Rongoa Māori: Wellbeing and Sustainability



This research was undertaken by the Institute of Environmental Science and Research Ltd and the Ministry of Health.

Through two literature reviews, this research examined healer focus groups and stakeholder workshops and how Rongoā Māori contributes to indigenous wellbeing. The research also identifies issues for the ongoing sustainability of traditional Māori healing in New Zealand. For a synopsis of the issues examined in this research a summary report is available.

An electronic link to this report can be found on the Māori Health website www.maorihealth.govt.nz



An investigation of the phenomenon of non-consensual sex among Māori men who have sex with men

Authors: Aspin C et al

Summary: These researchers discuss their findings from their investigation into instances of non-consensual sex (NCS) among men. They note that the research reveals that men who have sex with men experience higher rates of NCS than do other men and that these men are likely not to report that they have been subjected to NCS largely because there are no support systems in place for them. For a long time, there has been an expectation that while men might perpetrate acts of sexual violence against women, they cannot be the victims of such acts. These factors are compounded for Māori men who experience NCS. These men report that they suffer a range of long-term health effects and that they are unable to access culturally appropriate services to help overcome the effects of these negative health outcomes. At the same time, Māori men report that they have managed to find support within their cultural networks. Support services for Māori men who experience NCS need to be established and they need to incorporate appropriate cultural components into their processes and services.

Comment: This paper was presented at the recent HRC Hui Whakapiripiri by two of the authors. I was especially impressed by the way they presented such a sensitive issue to the packed audience – with dignity, with humour and with honesty. I hope we continue to see more quality work from this team.

Reference: *Culture, Health & Sexuality*. 2009;11(1):35-49.

<http://tinyurl.com/po6n3n>

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Triple-combination pharmacotherapy for medically ill smokers: A randomized trial

Authors: Steinberg MB et al

Summary: This trial, conducted from 2005 to 2007 in a single primary care setting, recruited 127 smokers from the local community in order to evaluate extended duration of a triple-medication combination versus standard-duration therapy with the nicotine patch alone and 6-month abstinence rates in smokers with medical illnesses; all were ≥ 18 years and had predefined medical illnesses. Participants were randomised to receive either the nicotine patch alone for a standard 10-week, tapering course ($n=64$) or the combination of nicotine patch, nicotine oral inhaler, and bupropion ad libitum, for up to 6 months ($n=63$). Intention-to-treat analyses revealed abstinence rates at 26 weeks after target quit date of 35% for the combination group and 19% for the patch-alone group ($p=0.040$). The adjusted OR for abstinence in the combination group was 2.57 ($p=0.041$). The median time to relapse was significantly longer in the combination group than in the patch-alone group (65 days vs 23 days; $p=0.005$). Some side effects occurred more frequently in the combination group (for example, insomnia [25% vs 9%] and anxiety [22% vs 3%]), but the proportion of participants who discontinued study medications because of adverse events was similar in both groups (6%).

Comment: An important study that was undertaken with a 'real' population – that is people who have 'medical illnesses' and are seeing their GP or hospital provider. The 'patient-provider' encounter is a great opportunity to discuss smoking cessation and we can now safely say that triple therapy benefits most people trying to quit.

Reference: *Ann Intern Med*. 2009;150(7):447-54.

<http://www.annals.org/cgi/content/abstract/150/7/447>

Incarceration, incident hypertension, and access to health care: Findings from the Coronary Artery Risk Development in Young Adults (CARDIA) study

Authors: Wang EA et al

Summary: The independent association of prior incarceration with incident hypertension, diabetes, and dyslipidaemia was examined in data from the Coronary Artery Risk Development in Young Adults (CARDIA) study; a cohort of 4350 adults aged 18–30 years at enrolment in 1985–1986. The study also explored the association of incarceration with left ventricular hypertrophy on echocardiography and with barriers to health care access. A total of 288 participants (7%) reported previous incarceration. Incident hypertension in young adulthood was more common among former inmates than in those without incarceration history (12% vs 7%; OR 1.7); the association persisted after adjusting for smoking, alcohol and illicit drug use, and family income (adjusted OR 1.6). Incarceration was significantly associated with incident hypertension in those groups with the highest prevalence of prior incarceration, i.e., black men (adjusted OR 1.9) and less-educated participants (adjusted OR 4.0). Former inmates were more likely to have left ventricular hypertrophy (adjusted OR 2.7) and to report no regular source for medical care (adjusted OR 2.5).

Comment: Prison health is often down (or missing from) any list of health priorities. Yet prison rehabilitation programmes must include quality health care. Health services within prisons should undertake screening (including health check) and prevention programmes. And based on the findings from this study, people who have spent time in prison should be supported to have regular follow-up to monitor blood pressure and left ventricle size.

Reference: *Arch Intern Med*. 2009;169(7):687-93.

<http://archinte.ama-assn.org/cgi/content/abstract/169/7/687>

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