

# Māori Health Review™

RESEARCH REVIEW

10 YEARS

MAKING EDUCATION EASY SINCE 2006



Making Education Easy

Issue 63 – 2016

## In this issue:

- > *Lack of housing, hospital treatment and premature mortality*
- > *Māori and Pacific smoking rates remain unacceptably high*
- > *Sexual health behaviours of NZ secondary school students*
- > *Analysing socioeconomic deprivation at multiple levels*
- > *Residential mobility and CVD varies between NZ ethnic groups*
- > *The burden of transient ischemic attack in Auckland*
- > *Drivers of length of stay in a provincial NZ ED*
- > *Ngā Hua a Tāne Rore: the benefits of Kapa Haka*
- > *Kaumātua Day: Māori-led responses to the Canterbury earthquakes*

KINDLY SUPPORTED BY

**Asthma + Respiratory**  
FOUNDATION NZ

## CONGRATULATIONS TO

**Metua Daniel-Atutolu**, who won a \$500 Visa Prezzy Card by taking part in our recent Pacific Health Review Subscriber Survey. Metua is a Senior Lecturer in Nursing at the Manukau Institute of Technology.

## Tēnā koutou 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. Ngā mihi mahana ki a koutou katoa. Noho ora mai.

## 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.

For this issue, we are pleased to introduce a guest reviewer – Dr Christine M Kenney PhD, the Programme leader in Indigenous Disaster Research at the Joint Centre for Disaster Research, Massey University/GNS Science.

Nga mihi

### Matire

Dr Matire Harwood

[matire@maorihealthreview.co.nz](mailto:matire@maorihealthreview.co.nz)

## Lack of housing, hospital treatment and premature mortality: a cohort study of people in Counties Manukau district

**Authors:** Thornley S, Marshall R

**Summary:** This analysis of risk factors for mortality amongst people admitted to Counties Manukau inpatient facilities included 1182 individuals aged 15–75 years between 2002 and 2014, all of whom were identified by medical staff as having insufficient housing. During a median 5.7-year follow-up, 126 people (10.7%) died. Median survival of the cohort was 63.5 years, approximately 20 years less than the general population. The strongest associations with premature mortality in this study cohort were among people with cannabis-related disorders (adjusted HR 2.15; 95% CI, 1.10 to 4.22), diabetes (1.75; 1.05 to 2.93) and Māori ethnicity, compared to European and other ethnic groups, except Asian and Pacific (1.80; 1.14 to 2.85).

**Comment:** Census results confirm that rates of homelessness are increasing; and more so for Māori than non-Māori. This paper provides important information on what this means for our health system. International studies have shown that the prevention of and early interventions for homelessness benefit those affected as well as wider society. Hopefully, this paper stirs activity in the right places.

**Reference:** *N Z Med J. 2016;129(1440):84-93*

[Abstract](#)

**CLICK HERE** to read previous issues of Māori Health Review

## DHB Māori Health Profile Summaries 2015 (Bi-Lingual)

Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago have released DHB Māori Health Profile Summaries 2015 funded by the Ministry of Health. The summaries are bilingual in te reo Māori and English.

The 20 summaries include indicators of whānau well-being, housing and income, health service use and health status. They are publicly available and can be used by any individual or organisation with an interest in hauora Māori.

<http://www.otago.ac.nz/MHP2015>



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

[www.maorihealthreview.co.nz](http://www.maorihealthreview.co.nz)

a RESEARCH REVIEW™ publication

## Smoking prevalence in New Zealand from 1996–2015: a critical review of national data sources to inform progress toward the Smokefree 2025 goal

**Authors:** Ball J et al.

**Summary:** This analysis of findings from the Census, the New Zealand Health Survey (NZHS) and the Health and Lifestyles Survey (HLS) evaluated progress towards New Zealand's goal of becoming a smokefree nation by 2025. Data from the Census and the NZHS showing a decline in adult (age ≥15 years) daily smoking from 23–25% in 1996/97 to ~15% in 2014/15 are broadly consistent with findings from the HLS, which dates back to 2008. However, recent NZHS findings do not suggest substantive reductions in daily smoking prevalence, particularly for Māori and Pacific populations, with 2014/15 rates of 35.5% and 22.4% in these populations respectively, and no statistically significant change since 2006/07.

**Comment:** I saw a presentation earlier this year showing that 'political activity' to reduce smoking had significantly reduced since Dame Turia and Hone Harawira left parliament. I can't help thinking that this is associated with the results presented in this paper. I'm personally trying to find out more about what's working elsewhere – including the pros and cons of e-cigarettes – as we can't let the goal get away from us.

**Reference:** *N Z Med J.* 2016;129(1439):11-22

[Abstract](#)

## Changes in the sexual health behaviours of New Zealand secondary school students, 2001–2012: findings from a national survey series

**Authors:** Clark TC et al.

**Summary:** This analysis examined trends in self-reported sexual and reproductive health behaviours among New Zealand secondary school students, using findings from nationally representative health and wellbeing surveys conducted in 2001 (n=9699), 2007 (n=9107) and 2012 (n=8500). Logistic regression analyses revealed significant reductions over time in certain sexual outcomes: 'Ever had sex' (–6.9%; p<0.001); 'currently sexually active' (–2.3%; p<0.001); 'always use condoms' (–3.3%; p=0.006); 'condoms at last sex' (–7.0; p=0.002); 'contraception at last sex' (–5.8%; p<0.001) and sexually transmitted infections (–0.3%; p=0.001). However, there was no significant change over time in 'Always use contraception' (–1.4%, p=0.514). In 2012, Māori (OR 0.7), Pacific (OR 0.5) and socioeconomically deprived students (OR 0.7) were less likely to use condoms than students in 2001. Moreover, Māori (OR 0.6), Pacific (OR 0.4), Asian (OR 0.5), younger (OR 0.6), and socioeconomically deprived (OR 0.6) students were less likely to use contraception, compared to students in 2001.

**Comment:** Māori youth are less likely to use contraception/condom when they are depressed, are feeling low or are regular users of marijuana or other drugs. As a GP I'm comfortable to talk to young people about starting contraception, or provide free condoms; but I'm probably not addressing those other factors that support young people to use these adequately, as well as I should.

**Reference:** *Aust N Z J Public Health.* 2016;40(4):329-36

[Abstract](#)

## The association between socioeconomic deprivation and secondary school students' health: findings from a latent class analysis of a national adolescent health survey

**Authors:** Denny S et al.

**Summary:** This Auckland University research group used data from a nationally representative youth health survey to examine indicators of socioeconomic deprivation and how these indicators vary by demographic characteristics of adolescents. The 2012 survey included 8500 secondary school students. Latent class analysis grouped students by household poverty based on 9 indicators of household socioeconomic deprivation: no car; no phone; no computer; their parent/s worry about not having enough money for food; more than 2 people sharing a bedroom; no holidays with their families; moving home more than twice that year; garages or living rooms used as bedrooms; and, no parent at home with employment. Three groups of students were identified: 80% of students had low levels of household poverty across all indicators; 15% experienced moderate poverty; and 5% experienced high levels of poverty. Depressive symptoms and cigarette smoking were 2–3 times higher in the poverty groups compared to students not experiencing poverty. The relationship was less clear between overweight/obesity and household socioeconomic deprivation after adjusting for covariates. Students experiencing household poverty reported higher levels of depressive symptoms and higher rates of cigarette smoking if they lived in more affluent neighbourhoods than if they lived in low (quintile 1) socioeconomic neighbourhoods.

**Comment:** The standout result for me was the finding (which was statistically significant) that students experiencing household poverty but living in affluent neighbourhoods report higher rates of health risk and poor health outcomes. I wondered if these were related to bullying at school.

**Reference:** *Int J Equity Health.* 2016;15:109

[Abstract](#)

### Independent commentary by Dr Matire Harwood

Dr Matire Harwood (Ngapuhi) has worked in Hauora Māori, primary health and rehabilitation settings as clinician and researcher since graduating from Auckland Medical School in 1994. **FOR FULL BIO [CLICK HERE](#)**



### RACP MyCPD Program participants

can claim **one credit per hour** (maximum of 50 credits per year) for reading and evaluating Research Reviews.

FOR MORE INFORMATION [CLICK HERE](#)

## Consultations opened on the Health of Older People Strategy

A draft Health of Older People Strategy is out for public consultation, from 13 July through to 7 September 2016. The Ministry of Health is inviting you to provide feedback on the draft strategy, via a submission, on the online discussion forum, and through consultation meetings. The draft strategy and information on how to have your say is online, at [www.health.govt.nz/hopstrategy](http://www.health.govt.nz/hopstrategy)

*Your feedback is important in helping to build a strategy that prioritises the right set of actions for the health and well-being of older people in New Zealand.*

## To move or not to move? Exploring the relationship between residential mobility, risk of cardiovascular disease and ethnicity in New Zealand

**Authors:** Darlington-Pollock F et al.

**Summary:** These researchers investigated associations between residential mobility, risk of cardiovascular disease (CVD) and ethnicity in a cohort of 2,077,470 New Zealand residents aged ≥30 years. Encrypted National Health Index numbers were linked to individual level routinely recorded data. Binary logistic regression modelled the risk of CVD for the population stratified by ethnic group according to mover status, baseline deprivation and transitions between deprivation statuses. The analysis revealed variation between ethnic groups for the relationship between residential mobility and CVD. Furthermore, this ethnic variation was found to be strongly influenced by the inter-relationship between residential mobility and deprivation mobility.

**Comment:** The authors recognise the context for these results, i.e. colonisation and more recent urbanisation policies that contribute to the spatial distribution of Māori residency in Auckland. These findings also raise questions about why 'moving' in itself is strongly associated with increased CVD risk for Māori and Pacific people. They are more likely to report unfair treatment, based on their ethnicity, when looking for housing compared with NZ Europeans. Furthermore, reported experiences of racial discrimination when looking for housing is associated with negative mental and physical health outcomes, including self-reported CVD.

**Reference:** *Soc Sci Med.* 2016;165:128-40

[Abstract](#)

## Incidence of transient ischemic attack in Auckland, New Zealand, in 2011 to 2012

**Authors:** Barber PA et al.

**Summary:** The fourth Auckland Regional Community Stroke study (ARCOS IV) identified all hospitalised and nonhospitalised cases of transient ischaemic attack (TIA) that occurred over a 12-month period from 1 March 2011 in people aged ≥16 years usually resident in Auckland. During the study period, 785 people presented with TIA (402 [51.2%] women, mean age 71.5 years); 614 (78%) of European origin, 84 (11%) Māori/Pacific, and 75 (10%) Asian/Other. The annual incidence of TIA was 40, and attack rate was 63, in age-standardised rates per 100,000 population, standardised to the World Health Organization (WHO) world standard population. Approximately two-thirds of people were known to be hypertensive or were being treated with blood pressure-lowering agents, half were taking antiplatelet agents and just under half were taking lipid-lowering therapy before the index TIA. Of 210 people were known to have atrial fibrillation at the time of the TIA, only 61 (29%) were taking anticoagulant therapy, suggesting a failure to identify or treat atrial fibrillation.

**Comment:** An appropriate paper, given the recent 'Stroke Awareness' campaign fronted by Miriama Kamo. As the authors suggest, we don't diagnose, let alone treat, atrial fibrillation adequately in NZ. My impression is that Māori and Pacific people may be at increased risk for atrial fibrillation, given higher rates for rheumatic heart disease and heart failure.

**Reference:** *Stroke.* 2016;47(9):2183-8

[Abstract](#)

## Emergency department length of stay for Māori and European patients in New Zealand

**Authors:** Prisk D et al.

**Summary:** A demographic audit of a provincial New Zealand emergency department (ED) revealed a significantly shorter ED length of stay (LOS) among Māori versus European patients (mean LOS, 266.8 mins vs 315.9 mins, respectively), despite Māori having poorer health outcomes overall. The study researchers therefore sought to determine drivers of LOS in this ED. They reviewed 80,714 electronic medical records of ED patients from 1 December 2012 to 1 December 2014. In a stepwise regression procedure that accounted for patient factors of age, gender and deprivation score, ethnicity had no statistically significant effect on LOS. Māori were, on average, younger, less likely to receive bloodwork and radiographs, less likely to go to the ED observation area, less likely to have a GP, and more likely to be discharged and to self-discharge; all of these factors decreased their length of stay.

**Comment:** I've included this paper to highlight the incidental findings – that Māori attending this ED were less likely to receive investigations or have a GP, and more likely to be discharged or self-discharged. It would be interesting to know if guidelines were followed appropriately.

**Reference:** *West J Emerg Med.* 2016;17(4):438-48

[Abstract](#)

**Privacy Policy:** Research Review will record your email details on a secure database and will not release them to anyone without your prior approval. Research Review and you have the right to inspect, update or delete your details at any time. The views expressed in this Publication are personal to the authors, and do not necessarily represent the views or policy of the Ministry of Health on the issues dealt with in the publication.

**Disclaimer:** This publication is not intended as a replacement for regular medical education but to assist in the process. The reviews are a summarised interpretation of the published study and reflect the opinion of the writer rather than those of the research group or scientific journal. It is suggested readers review the full trial data before forming a final conclusion on its merits.

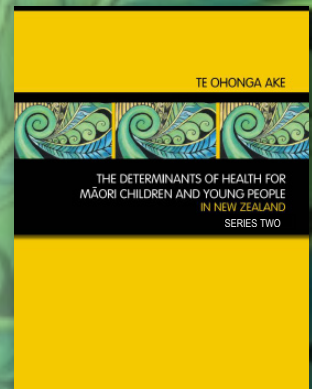
**Research Review publications are intended for New Zealand health professionals.**

**Do you have whānau and friends who should be receiving Māori Health Review, but they aren't health professionals?**

Just send them to [www.maorihealthreview.co.nz](http://www.maorihealthreview.co.nz) and they can sign up to get the review sent directly to their inbox.

## Te Ohonga Ake: The Determinants of Health For Māori Children and Young People in New Zealand: Series Two

This report was released on the 29th of April. Funded by the Ministry of Health and produced by the NZ Child and Youth Epidemiology Service of the University of Otago, the report provides a snapshot of progress addressing many of the determinants of health including child poverty and living standards, housing, early childhood education, oral health, tobacco use, alcohol related harm, and children's exposure to family violence. The report is available to download at: <http://www.health.govt.nz/publication/te-ohonga-ake-determinants-health-maori-children-and-young-people-new-zealand-series-two>



## Ngā Hua a Tāne Rore The Benefits of Kapa Haka

**Authors:** Pihama L et al.

**Summary:** This report arose out of consultation with kapa haka practitioners and interested government agencies. It not only describes empirical evidence in support of the cultural, social, health, education and economic impacts of kapa haka, but also details how kapa haka is able to facilitate meaningful connections with other cultures.

**Comment:** A number of students have asked about evidence on the benefits of kapa haka – hence the inclusion of this report for this month's review.

**Reference:** *Ngā Hua a Tāne Rore The Benefits of Kapa Haka: Scoping the research needs and options for developing a better understanding of the contribution that Kapa Haka makes to Aotearoa New Zealand society. 2014. Wellington: Ministry for Culture and Heritage.*

[Abstract](#)



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](#)

Journal of  
**INDIGENOUS WELLBEING**  
Te Mauri - Pimatisiwin

Te Rau Matatini is pleased to announce the first Aotearoa led release of the **free online peer reviewed Journal of Indigenous Wellbeing - Te Mauri Pimatisiwin.**

It provides accessible, evidence based articles to academics, policy makers and people working at the grassroots level.

<http://journalindigenouswellbeing.com/>

## GUEST REVIEWER: DR CHRISTINE M KENNEY PhD

### Kaumātua Day: a Māori community-led approach to addressing the health and wellbeing needs of elderly Māori following the Canterbury earthquakes

**Author:** Kenney C

**Summary/Comment:** Within the disaster response and research sectors, there is increasing recognition of the value of community-led initiatives that facilitate emergency management, mitigate health risks as well as foster community well-being. In contrast, the value of culture-based approaches to addressing disaster recovery has rarely been acknowledged. Recent kaupapa Māori research conducted in Christchurch suggests that Māori response initiatives were characterised by collaborative accountability, authority, agency, and actions, because within a Māori paradigm, a hierarchically-structured 'command and control' approach to facilitating community recovery has proven to be ineffective. Māori-led responses in Canterbury were found to be consistently shaped by kaupapa (cultural values) and highly effective in addressing the needs of local communities. Research findings may be usefully drawn upon to enhance public health and emergency management policies and practices.

When the Canterbury earthquakes commenced, Ngāi Tahu, as kaitiaki, had an obligation to ensure the wellbeing of all Christchurch residents. After the February 22<sup>nd</sup> earthquake in 2011, a national Māori Recovery Network was established, and Te Rūnanga o Ngāi Tahu coordinated community support. The eastern suburbs of Christchurch were most severely impacted by the earthquakes. As these suburbs are home to the majority of urban Māori, many Kaumātua were disproportionately affected with reduced access to basic necessities, sanitation, power, transport and support from frontline responders. Māori elders with significant health and mobility issues were particularly marginalised, due to isolation in unsafe homes. Access to appropriate and culturally acceptable health services was also very limited. Consequently, Māori elderly experienced increased rates of illness and a corresponding deterioration in psychosocial wellbeing. In response, five Māori women with community leadership and service expertise collaborated to develop a community-led initiative, 'Kaumātua Day', in order to facilitate psychosocial and material support for elderly Māori living in the eastern suburbs. Seed funding was accessed from both the Todd and Tindall Foundations and the initiative was implemented in March 2012, in accordance with Māori collective values. Specific Kaumātua Day goals included:

1. Reducing social isolation by supporting elderly residents to meet several times a month; and
2. Supporting social connectedness by facilitating group aspirations, entertainment, dinners and opportunities for intergenerational socialisation; and
3. Facilitating access to material, social and health resources/services for those who were mobility impaired, geographically/socially isolated and/or experiencing elder abuse.

Since inception, Kaumātua engagement with the initiative has gradually increased. Currently, approximately 170 Māori elders participate on a semi-regular basis. Due to the initiative's effectiveness, Kaumātua Day has expanded to provide outreach services for the wider elderly community in Eastern Christchurch. Key factors in the initiative's success include the Māori collectivised approach to leadership as well as the enactment of traditional cultural values and practices, which offer a counterpoint to commonly applied 'command-and-control' approaches to managing the health risks of elderly Māori who reside in post-disaster contexts.

**Reference:** *Five Māori women community leaders volunteer to reduce earthquake impact on elderly residents in Eastern Christchurch. In UNISDR (Ed). Women's Leadership in Risk-Resilient Development (pp. 65-70). Bangkok: United Nations Office for Disaster Risk Reduction.*

[Abstract](#)

#### Independent commentary by Christine Mārama Kenney

Dr Christine Mārama Kenney (Ngāi Tahu, Te Ātiawa, Ngāti Toarangatira) is the Programme leader in Indigenous Disaster Research at the Joint Centre for Disaster Research, Massey University/GNS Science. Christine has a particular interest in improving the wellbeing of Indigenous peoples impacted by disasters and has a strong record in implementing community-based disaster research and policy projects with Indigenous communities in Canada, Taiwan and Australia. Further to the 2010–2011 earthquakes in Canterbury, Christine has primarily been engaged with Māori communities throughout New Zealand. She has conducted and is leading research projects in Aotearoa that focus on identifying factors that build Māori community resilience and sustainability in response to adversity, the role of traditional knowledge and practices for informing disaster risk management, and building indigenous community preparedness and response capacity. In addition, she is partnering with other researchers in exploring natural hazard risks in the Bay of Plenty and Hawke's Bay. Dr Kenney is actively engaged with or on behalf of her respective iwi and her activities include participation in Te Piringa o Te Awakairangi (Wellington regional marae disaster management committee) and the New Zealand Red Cross National Māori advisory group. Dr Kenney's commitment to culturally relevant disaster risk management is internationally recognised and evidenced by invitations to give keynote addresses at United Nation's Summits (2014 UNSIDS Summit, and 2014 UNESCO Summit on Education for Sustainability) and other key conferences (2014 Pacific Risk Management Conference-PRiMO). Christine was appointed to New Zealand's diplomatic delegation to the intergovernmental preparatory meetings for the 2015 United Nations' Global Conference on Disaster Risk Reduction and subsequently participated as a member of the New Zealand delegation.

