Te Ora Conference Abstracts

8 - 9 April, 2000. Hauiti Marae, Tolaga Bay

Te Arotakenga – The Application of Whare Tapa Wha To Specialist Psychiatric Practice

Dr Erihana Ryan, Te Korowai Atawhai, Healthlink South

The application of Maori health policy statements to health service provision has resulted in some structural changes, few governance changes to mainstream services over the past decade. In these developments translation of structural change to universally accepted and applied practice of Maori health into mainstream services has been ad hoc; driven by the tenacity and passion of Maori working within the services rather than by an acceptance of the need for development of a new model of practice based on application of whare tapa wha, te wheke, and nga pou mana.

In the development of Te Arotakenga, Te Korowai Atawhai (Maori mental health unit in mental health division of Healthlink South) has introduced a standardised practice that is the basis of subsequent management of tangata whai ora and their whanau; ensuring that understanding and responding to the experience and resonance of their cultural life is a primary basis for response to the illness patterns that bring them to the service.

ACC working effectively with Maori communities to reduce injuries among Maori

Joyce-Anne Hankins, Programme Manager Cultural Strategies – ACC Injury Prevention

Injury, unintentional and intentional, has been identified as a leading cause of mortality and morbidity among Maori. ACC is committed to reducing the social, economic and physical impact of personal injury on individuals and the community. Strategies include providing funding support and engaging stakeholders in design, implementation and evaluation of effective injury prevention programmes.

The purpose of ACC Injury Prevention is " to promote measures to reduce the incidence and severity of personal injury in relation to the persons and injuries".

The Cultural Strategies programme focuses on preventing injuries sustained by Maori, and strategies include establishing effective partnerships with the Maori communities and providing Maori with the opportunities to deliver injury prevention programmes that meet their self-defined needs and compliment the business of ACC The Cultural Strategies programme is based on identification, accountability, empowerment and Tino Rangatiratanga.

This presentation will examine the process, procedures and opportunities ACC Injury Prevention is making available to Maori communities to enhance the lives of individuals. This programme has the continued backing of ACC's Senior Management.

Vocational education and training for GPs in the new millennium

Peter Morrow, RNZCGP

The General Practice Education Programme (GPEP) consists of Stage 1: the Intensive Clinical Training Programme and Stage 2, the Advanced Vocational Education Programme (Accreditation). Satisfactory completion of Stage 2 leads to the qualification of Fellowship of the RNZCGP. Fellows of the College are eligible to apply to the Medical Council for Vocational Registration.

The challenges for the RNZCGP include recruiting Maori registrars to Stage 1 of the programme and recruiting Maori GPs as teachers for Stage 1. A further challenge is to increase the number of Maori GPs who are Fellows of the College Proposals being considered for the future include distance education strategies, which support GPs through Stage 1. Information technology is increasingly important for peer review groups and peer support, recognised for the purposes of Stage 2 and beyond

Working in partnership with Te ORA provides the College with opportunities to meet these challenges and support general practitioners.

Progressing the Development of Hauora Maori - The Internet Site for Maori Health

Martin Entwistle, MB ChB, MBA, FRCSEd

Hauora Maori has been running for the last 12 months and continues to receive a growing number of visitors, 19,000 hits in February. Phase 1 of the development programme is now complete. Users have access to a range of information and

resources as well as a discussion group, which is being updated to make it more user friendly.

We now plan to implement Phases 2 and 3, which will include more extensive content including a news area, workplace resources and disease management programmes. The last phase will progress the development of an Online Journal of Maori Health carrying both original studies and review material.

There is the opportunity to take a leadership role in First Nations Health, by assisting the sharing of issues and experiences. This process has begun with the establishment of a searchable database of relevant resources, but the focus will remain on activities which improve health outcomes for Maori.

Funding is required to support these developments and a programme is underway to identify suitable sponsors. Contact has already been made with the Ministry of Health, Te Puni Kokiri, the Health Funding Authority and a range of Commercial Sponsors.

Maori Illness perceptions in a Traditional Maori healing clinic

Dr Hinemoa Elder, Medical Student

There is substantial evidence of continuing Maori health inequities and under utilisation of health care resources. Knowledge of Maori illness perceptions will provide a base for understanding more about Maori health seeking behaviour. This will enable modification and development of services in response to that understanding and potential improvement in health outcomes for Maori people.

This pilot qualitative study aims to describe how Maori illness perceptions are expressed using the dimensions of Leventhal's illness perception model. The research aims to explore how Maori concepts of both health and illness are expressed using the illness perception framework.

These findings shows that the illness perception dimensions are valid and meaningful for these Maori patients in this context. These participants express three themes running through the illness perception dimensions. These are "whanau", "income" and "faith". These themes as well as the determinants of health described by these participants are consistent with models of Maori health such as Te Whare Tapa Wha.

Prevalence of Sleep Problems And Sleep Apnoea Risk Factors Among Māori and Non-Māori: a National Survey

R Harris, B Robson, P Workman, P Reid, P Gander

Te Rōpū Rangahau Hauora a Eru Pōmare and the Sleep/Wake Research Centre, Wellington School of Medicine, University of Otago.

Little is known about the prevalence of sleep complaints or sleep disorders in New Zealand Sleep clinics have reported a disproportionate number of Māori presenting with more severe obstructive sleep apnoea (OSA). To estimate the prevalence of sleep problems and factors associated with OSA among Māori and non-Māori adults, and to examine their possible relationships to other known disparities between the health of Māori and non-Māori.

In April 1999, a two-page questionnaire was sent to a sample of 10,000 New Zealanders (5,500 of Maori ancestry and 4,500 non-Maori) aged 30-60 years, selected at random from the electoral roll. A 71% response rate was achieved.

Māori men and women reported significantly higher prevalences for a number of factors associated with OSA compared to non-Māori men and women. These include habitual snoring, observed apnoeas and excessive daytime sleepiness. Mean neck size was also larger for Māori men (42cm) and women (36cm) compared with non-Māori men (40cm) and women (34cm)

The results suggest that the prevalence of OSA may be higher among Māori, especially Māori men. This study has implications for the purchase and development of treatment services for sleep disorders in New Zealand, and also clinically, with the likely higher need among Māori demanding priority The study provides a model for examining health issues whereby the needs and risks for Māori can be assessed to the same level of analysis as non-Māori.

Maori and Injury – a review of mortality

Jo Baxter, Public Health Registrar

Injury is the biggest cause of morbidity and mortality in young Maori. In the light of the extreme impact of injury on Maori health, injury prevention has been designated as a health gain priority area by the Health Funding Authority

This paper describes Maori mortality due to injury. The main causes of death and patterns related to age and gender. Key issues for health gain and injury prevention are discussed. The paper uses mortality data from the New Zealand Health Information Service.

Injury is the leading cause of mortality for young Maori. Motor vehicle accidents and suicide account for the majority of injury deaths. Maori have significantly higher rates of injury deaths than non-Maori in most age-groups, the extreme elderly being the exception. There are differing patterns of injury mortality in Maori and non-Maori – in particular falls in elderly non-Maori females are a major cause of non-Maori female death however provide only a small proportion of Maori female deaths. Maori males have higher mortality than females and rangatahi and young adults having highest rates overall.

Premature Maori death due to injury, particularly in the young is a tragedy. Injury constitutes an urgent and high priority area for Maori health. There are links with other key health areas, in particular mental health and alcohol and drug disorders and very strong links with public health. In particular, factors associated with deprivation including safe housing, roading and vehicles are important.

6-8 April 2001. Rakeiao Marae

Heart Failure and mortality rates between Maori and non-Maori New Zealanders for the period 1988 - 1998

Dr Tania Riddell

Retrospective ecological study that compares heart failure hospitalisation and mortality rates between Maori and non-Maori New Zealanders for the period 1988 - 1998.

Results clearly demonstrate non-independence of deprivation and ethnicity. Heart failure mortality and morbidity rates in this study were found to be six to eight times higher among Maori compared to non-Maori aged 45–64 years; and two to three times higher for Maori in the age group 65 years and older. After controlling for deprivation, Maori mortality and hospitalisation rates reduced only slightly to four to five times those of non-Maori aged 45 - 64 years, and remained twice those of non-Maori aged 65 years and older.

The results of this study are interpreted within a 'Gap framework', and have implications for health policy in New Zealand

Hei Ako-The Teaching and Learning Continuum

Peter Jansen MBChB, FRNZCGP, Cert Clin Teach
Dale Sheehan Christchurch College of Education

Dr Peter Jansen and Dale Sheehan will discuss teaching and learning in clinical contexts from a Maori perspective. Different environments can be used for clinical training and this presentation will address the role of environment and context in determining the framework and style of teaching. They will examine the use of this style in teaching Maori about adult learning principles in relation to teaching Maori health workers. They will draw on their experiences of both teaching and learning within a wananga model, using aspects of the environment, history and experience as teaching tools. The wananga model has been used for the successful Maori clinical teachers programme in 2000.

Maori and Stroke Rehabilitation

Dr Matire Harwood

Studies from around the world confirm that ethnicity is a consistent and significant variable for stroke incidence and mortality, risk factor prevalence and management, and functional and motor impairments. Recently completed research at the Rehabilitation Research and Training Unit, Wellington School of Medicine compared resource utilisation and stroke outcomes for different ethnic groups in New Zealand (European, Māori and Pacific Island populations). These results will be presented within the context of international stroke medicine.

Doctors' Hours of Work: Where We Are, and Where We Are Heading

Philippa Gander and Sandy Garden, Sleep Wake Research Centre

The extended and irregular hours of work that are commonplace in medical practice can have a negative impact on both patient safety and practitioner health. These effects occur because human performance is systematically degraded by prolonged wakefulness, inadequate sleep, and at unfavourable times in the daily cycle of the circadian biological clock. Any 24-hour workplace must actively manage these issues. In 1999, the Australian Medical Association (AMA) took the significant step of adopting a national code of practice addressing hours of work, shift work, and rostering for hospital doctors. The AMA highlighted decreasing community tolerance of the potential risks for patient safety associated with traditional work patterns, as well as the risks to doctors themselves.

We have applied to the Health Research Council for funding for 3 inter-related studies that aim to document current work practices in New Zealand, compare them to the AMA guidelines and other international initiatives, and make recommendations about how improvements might be achieved.

1. The first study would review the Workforce Survey data collected by the Medical Council, to provide an overview of typical work patterns of doctors at different stages in their professional development, and in different areas of specialisation. The Medical Council has given it permission and support for this study.

2. The second study would distribute an anonymous in-depth questionnaire to all Resident Medical Officers working in New Zealand hospitals. This study will focus particularly on how current work practices rate in the risk assessment model detailed in the AMA guidelines. This study has the support of the Resident Doctors Association.

3. A detailed review of relevant literature and other international initiatives (for example in the European Union) would be undertaken to provide a broad context for ongoing debate, and guide recommendations for possible improvements in practice standards.

Our discussions with Drs Papaarangi Reid and Elana Curtis have lead us to expect that long and irregular hours of work may create particular stress for Māori doctors who are also expected to take an active role in the community life of the whanau. In addition, Māori are not yet represented proportionally in the medical workforce (2.2% of doctors identified as Māori in the 1999 Medical Workforce Survey, while 14.5% of New Zealanders identified as Māori in the 1996 census). Furthermore, the burden of disease is markedly greater among Māori than non-Māori people It therefore seems likely that some Māori doctors may carry an exceptionally heavy workload, particularly in general practice. Dr Jo Baxter's recent survey of Māori doctors' training needs reflects these issues[1].

Based on the 1999 Medical Council Work Survey, we anticipate that 2-3% of the respondents in Study One will be of Māori descent. We would also expect there to be at least 70 Māori doctors who would be potential participants in Study 2. Because of these issues, we would like to collaborate actively with Te ORA at all stages of the project. We are seeking funding for a Junior Research Fellow to manage Māori data collection and analyses, and to co-ordinate dissemination of study findings to Māori. We would like to discuss how we can collaborate with Te ORA to maximise the benefits of this work for Māori doctors and the Māori community.

1. Baxter J. 2000. Kōkiritia. *An Analysis of Māori Doctors' Training Needs*. Report prepared for Te Ohu Rata o Aotearoa

Te Reo Hauora

Dr David Jansen, Ngati Raukawa, MBChB, BHB, BA, Dip Tchng, Grad Cert Clin Tch

I te tau 2000 ka whakawhiwhia nei e ahau te karahipi no Eli Lilly and Company hei awhina i ahau ki te tuhi i tetahi pukapuka reo Maori. Ko te kaupapa nei ka whakaarohia roatia nei hei awhina i te rata Maori, i te tauira rata Maori hoki i ana mahi me te turoro Maori. Tokomaha o matou te rata Maori e pirangi ana ki te reo Maori,, ki te korero i te reo ki o matou turoro[1], heoi ano kaore e nui nga pukapuka hei whakamamama.

Ko taku ka tuhia nei ka whai i te kaupapa pataitai a te takuta, ara ko te take ka haere mai te tangata ki te rata, te hohipera ranei, katahi ko nga patai mo ahuatanga o te mate, katahi ka whai era patai mo te whakapapa mate o te tangata me tona whanau, haere tonu, haere tonu. Kaore e rereke te ahuatanga o nga patai ka pataihia e te rata Maori, engari pea ka rereke te ahuatanga o te tangata.

Ka mutu kaore ano kia mutu te tuhi, ka whakaatuhia te tuhinga tuatahi mo te pukapuka nei. E toru pea nga whakaritenga kei te toi, kia aromatawaia te tuhinga tuatahi, ko te whakaahua hei awhina me te kohi i etahi atu patai, korero ranei hei whanui ake nga kaupapa. Ara, kua tukuna atu te pukapuka ki etahi o nga tangata e matatau ki te reo, ma ratou e whakawa mena e tika ana, he korero ano pea hei kawe i te tikanga Tuarua ka tukuna atu ki te Taura Whiri i te Reo, ma ratou ano e whakatika, a kei a ratou etahi kupu atu, he kupu tawhito pea, he kupu hou pea kua waihangaia hei tautoko i te reo Maori e kawe i nga kaupapa o tenei ao. Kua rongo korero ahau mai i tetahi o nga kairehu kei te pirangihia tetahi wahanga mo o ratou patai. Kati ra kei te haere tonu tenei mahi a hei te wa ka tutuki ai.

Aotearoa Women's Health Initiative (AWHI)

New Zealand women aged 49-69 years: a longitudinal study including an observational study and an RCT in collaboration with WISDOM (Women's International Study of Long Duration Oestrogen after Menopause).

Dr Beverley Lawton (Dept of General Practice, Wellington School of Medicine)
Prof. Tony Dowell (Dept of General Practice, Wellington School of Medicine)
Dr Sally Rose (Junior Research Fellow, Dept of General Practice, Wellington School of Medicine) New Zealand
Dr Anna Fenton, (Endocrinologist, Christchurch)
Prof. Peter Stone (Obstetrics & Gynaecology, Auckland School of Medicine)

Dr Papaarangi Reid, Eru Pomare Health Research Centre, Wellington School of Medicine

New Zealand is a multicultural society made up of different ethnic groups including indigenous Maori, who form 14% of the population. Although this group has a significantly lower life expectancy and a higher mortality and morbidity rate than non-Maori, little is known about the menopausal experience of Maori women.

The Aotearoa Women's Health Initiative (AWHI) encompasses two studies: an observational study that aims to describe disease outcomes, clinical, metabolic and socio-demographic profiles of Maori and non-Maori women; and a randomised controlled trial (RCT) of hormone replacement therapy (HRT). The RCT is being carried out in collaboration with the British Medical Research Council's WISDOM study and will assess the risks and benefits of long-term HRT use with particular reference to cardiovascular disease, breast cancer and osteoporosis. These endpoints have particular relevance to Maori women who suffer substantially higher rates of coronary heart disease than non-Maori, and have the potential to benefit from interventions such as HRT.

A pilot study has screened 200 women from a variety of ethnic backgrounds (including 12% Maori and Pacific Islanders) to determine their eligibility to join the RCT. Women unwilling or ineligible to join the trial are being followed in the longitudinal observational study. Extensive cross-sectional data has been collected on this group of women including socio-demographic information, experience of menopausal symptoms and HRT use. These results indicate that 50% of the women screened have taken HRT at some stage in their lives, and that 30% are currently taking HRT. AWHI has received substantial funding from the British Medical Research Council to extend the WISDOM study nationally in New Zealand. Recruitment for the ten year longitudinal trial will commence in April 2001. At present endorsement and local funding is sought in New Zealand.

Given the frequency with which HRT is being used in New Zealand, the high morbidity rate of Maori women, and the trend towards an ageing population, the need to establish the balance between the risks and benefits of HRT use becomes even more timely for New Zealand women.

Inquiry into Cannabis Law Reform

Dr David Gilgen, Raukura Hauora o Tainui

Alcohol and nicotine pose significant health hazards for Maori. Cannabis within the frame of reference that I work is also an important cause of morbidity. In my contact with patients, whanau, paramedical caregivers the police, lawyers, social workers and school teachers the overwhelming opinion is that cannabis is harmful.

Conversely, those advocates of legislation or law reform of marijuana use, all insist the drug is harmless, it makes you 'happy' and it is not addictive.

Addiction is a complex human and societal problem. It must be addressed from at least a threefold perspective: prevention and therapy. A synergy of success results when all three are used in concert.

Whakawhitiwhiti korero; A House Officer rotation in a Maori Primary Health Care Setting

Dr Hinemoa Elder, House Office/Locum GP, Piritahi Hauora, Waiheke Island

A three month house officer rotation at Piritahi Hauora was undertaken through support from the Piritahi Marae community, NCTN, South Auckland Health Integrated Care and two General Practitioners. This invaluable experience further supports the findings of "Kokiritia" and now provides a recognised rotation option to begin to meet early post graduate training needs of Maori Doctors.

During this rotation a qualitative study was undertaken which aimed to describe the illness and health perceptions of Maori patients as well as concepts of patient satisfaction and quality of care. Kaupapa Maori study design was employed utilising the "whakawhitiwhiti korero" style outlined in a previous study. This study found that the theme of "whanau" was a key determining influence on perceptions of health and illness as well as patient satisfaction and quality of health care perceptions. This challenges the existing theoretical model which emphasises the individual as central to illness perception. This study firstly provides support for existing whanau based services across the health sector. And secondly underlines the importance of whanau-conscious health care interactions.

A profile of Maori and non-Maori hospitalised for deliberate-self-harm over 12 months

Dr Joanne Baxter

Background: Despite concerns over Maori mental health and suicide / attempted suicide, there remains little research that describes patterns of hospitalisation or outcome for Maori admitted for deliberate-self-harm.

Aim: This study aims to describe the characteristics of all Maori and non-Maori hospitalised over a 12 month period (1993) for deliberate-self-harm. Subsequent outcomes with regards to further hospitalisations (3 years) or mortality (4 years) for deliberate-self-harm or suicide are described in later studies.

Design: This is an historical cohort study using NZHIS data collected as part of the National Minimum Data Set. Data from all individuals hospitalised commencing between Jan 1 1993 and Dec 31 1993 are included in this cohort. The first hospitalisation for individuals is counted and all subsequent hospitalisations are counted as subsequent admissions.

Findings: 2333 individuals were hospitalised with an injury code for deliberate-self-harm. 17.7% were Maori. Maori youth population rates were concerning with hospitalisation Maori were over 3 times those for non-Maori in ages 10-14, and over 2 times higher in all ages 15–25. This study describes the characteristics of the cohort of all those hospitalised for deliberate-self-harm in New Zealand in 1993 with a particular focus on Maori and non-Maori aged under 65 years. When compared to non-Maori, Maori hospitalised for deliberate-self-harm are younger (mean and median age 5 years younger), more likely to be hospitalised for 'physical methods' of self-harm, less likely to have prolonged hospitalisations and more likely to be self-discharged. There was no major difference in proportions by gender or diagnosis.

Conclusion: This cross-section highlights the high rate of young Maori hospitalised for deliberate-self-harm and suggest increased morbidity / risk of deliberate self-harm within the Maori population that is young.

Implications: Strategies for suicide prevention need to include a focus on population based strategies relating to mental health in Maori and young Maori. This is in addition to risk factor based strategies or treatment, management strategies.

The recognition of an attention deficit disorder (ADHD) in the pre-school child

Dr Leo Buchanan, Paediatrician, Hutt Hospital, Lower Hutt

Trying to decide when hyperactivity truly exists can be tricky. Anxiety states; poorly controlled asthma and bonding issues may be important. Dysfunctional family situations can frequently be associated but ADHD is highly genetic and sometimes the same problem can be present in the whanau. All of these situation can e highly relevant to the care and health of our tamariki.

Rongoā Māori and Primary Health Care

Rhys Jones

The traditional Māori system of healing has been transformed by the colonisation process and overshadowed by the dominance of Western scientific medicine. Over the past two decades, however, there has been a resurgence of interest in rongoā Māori, prompting many calls for it to be formalised within new Zealand's health care system. Despite these recommendations, traditional Māori healing is still practised largely in isolation from the mainstream health sector.

The aims of this study were to identify the major issues involved in incorporating traditional healing into primary health care and to look at how this might be achieved. The research was guided by Kaupapa Māori Research theory, and a qualitative approach was used. In-depth interviews were conducted with eighteen participants including traditional healers, Māori general practitioners, representatives of Māori health providers and professional bodies, and policy and funding organisation representatives. Thematic analysis of interview data was performed using a general inductive approach.

In general, the idea of incorporating rongoā Māori into primary health care drew a positive reaction from the study participants. The major issues that emerged were concerned with interaction between practitioners, professionalisation, and financial considerations. Underpinning themes were the philosophy of Māori development and the principles of the Treaty of Waitangi, particularly the concept of partnership. Ultimately, the ability of the health system to embrace Māori perspectives of health could not only bring direct health benefits, but could also reaffirm the significance of traditional healing as a legitimate Māori cultural asset.

1. Kokiritia, J Baxter, Te Ohu Rata o Aotearoa, 2001.