

Journal Abstracts

EDITOR: DAVID TIPENE-LEACH

Culture and women's mental health: International perspectives and issues for Aotearoa/ New Zealand.

Baxter, Joanne

In: Romans, Sarah E. (Ed). (1998). *Folding back the shadows: A perspective on women's mental health*. (pp. 63-86). University of Otago Press.

Defines concepts of culture, ethnicity and race before discussing issues related to culture, mental health, psychiatric research and feminist research. This is followed in Part 2 by a study of the mental health of Maori women. Maori women are a group of indigenous New Zealand women who have Maori whakapapa (genealogy) and who identify themselves as Maori. The section begins with aspects of a Maori woman's world-view and its relationship to health and well-being, incorporating Maori health concepts. This is followed by a demographic, socioeconomic and health profile of contemporary Maori women. Current knowledge of Maori women's mental health and rates of mental illness is followed by comments regarding research and specialized Maori mental-health services. Maori women have high levels of risk factors for mentally ill health. From a Maori perspective these risks are inseparable from spiritual, physical and "whanau" dimensions of health. From a socioeconomic and demographic perspective, high levels of relative deprivation of Maori women are risks for mental ill health. The challenge for mental-health professionals in New Zealand is to understand issues for Maori with mental-health needs and the differences in outcomes for Maori who use these services.

There were striking differences in dietary habits, food selections and cooking practices between European, Maori and Pacific Islands participants. Dietary intakes of Maori workers were closer to those of Europeans than those of Pacific Islands participants.

Dietary intakes of middle-aged European, Maori and Pacific Islands people living in New Zealand.

Metcalfe PA. Scragg RK. Tukuitonga CF. Dryson EW. *New Zealand Medical Journal*. 111(1072):310-3, 1998 Aug 28.

AIM: To compare dietary intakes of Maori, Pacific Islands and European men and women in New Zealand. METHODS: A food frequency questionnaire was used to calculate nutrient intakes of 5523 New Zealand workers aged 40 years and over (3997 men, 1524 women) from a cross-sectional survey carried out between 1988 to 1990. RESULTS: Compared with European men and women, Maori women and Pacific Islands men and women consumed larger amounts of total energy per day. Age-adjusted nutrients expressed as percentage contribution to total energy intakes showed that Maori and Pacific Islands men and women consumed less carbohydrate, fibre and calcium, and more protein, fat, saturated fat and cholesterol than European men and women, respectively. These results were consistent with fewer servings of cereal and cheese per month, and more servings of red meats, fish and eggs in Maori and Pacific Islands participants compared with Europeans, after adjusting for age and total energy intakes. Pacific Islands men and women also consumed more servings of chicken, fewer cups of milk and fewer servings of fruit per month compared to Europeans. Maori men and women consumed more slices of bread and fewer servings of vegetables per month compared to European men and women.

CONCLUSIONS: There were striking differences in dietary habits, food selections and cooking practices between European, Maori and Pacific Islands participants. Dietary intakes of Maori workers were closer to those of Europeans than those of Pacific Islands participants.

Ethnic differences were due to larger portion sizes and increased frequency of most foods in Maori and Pacific Islands participants. Maori have high rates of breast cancer despite having a more favourable profile than non-Maori for most identified risk factors.

A clinical sample of Maori being treated for alcohol and drug problems in New Zealand.

Huriwai T. Sellman JD. Sullivan P. Potiki T. *New Zealand Medical Journal*. 111(1064):145-7, 1998 Apr 24.

AIMS: To document key clinical characteristics of a group of Maori being treated for alcohol and drug problems; compare the characteristics of Maori accessing dedicated Maori alcohol and drug treatment services with Maori accessing non-dedicated services; and investigate these clinical characteristics in relation to patient satisfaction. METHODS: A sample of 105 Maori with alcohol and drug problems, accessing the range of treatment services in the Canterbury area, undertook a semi-structured interview. RESULTS: Overall this sample of Maori were socially disadvantaged. Their main drug of use was alcohol, followed by cannabis,

opioids and sedatives/hypnotics. There were no significant differences between the subjects who attended Maori dedicated services and those who attended non-dedicated Maori services in terms of demographic variables, alcohol and drug use history, current level of dependence, or anxiety/depression state. Subjects in dedicated Maori services were more likely to have had greater than 21 days of treatment compared to those in non-dedicated Maori services and were more likely to have been to their home marae than those in non-dedicated services. In multivariate analysis, Maori in dedicated Maori services were significantly more likely to be satisfied with treatment than those in non-dedicated services (odds ratio = 5.5, 95% confidence interval = 1.81-16.78). **CONCLUSION:** Further research is required to investigate the relationship between high patient satisfaction by Maori with alcohol and drug problems attending dedicated Maori treatment services, treatment effectiveness and the components of dedicated Maori services that may contribute to higher retention rates, greater patient satisfaction and increased positive treatment outcome.

Breast cancer in Maori and non-Maori women.
McCredie M. Paul C. Skegg DC. Williams S.
International Journal of Epidemiology. 28(2):189-95, 1999 Apr.

Breast cancer is more common in Maori than in non-Maori women under the age of 40 years and is equally common in older women, despite Maori being generally of lower socioeconomic status and having had a higher fertility rate than non-Maori.

Data from a nationwide population-based case-control study of breast cancer in New Zealand women aged 25-54 years were used to compare the age-adjusted distribution of reproductive and other risk factors for breast cancer in self-identified Maori and non-Maori women from the control group. Separate analyses also were carried out for women aged 25-39 years and for those aged 40-54 years. The risk of breast cancer according to the proportion of Maori ancestry was estimated using multiple logistic regression simultaneously adjusting for several risk factors.

Significant differences were found between self-identified Maori and non-Maori women in the age-adjusted frequencies for education level, socioeconomic status, age at first full-term pregnancy, parity, and duration of breastfeeding; the profile in all instances suggesting a lower risk of breast cancer for Maori than for non-Maori. There were no significant differences with respect to age at menarche, surgery for benign breast disease or a family history of breast cancer. Significantly more Maori than non-Maori were in the highest

quartile of recent body mass index. Women self-identified as Maori has an approximately twofold higher risk of breast cancer than non-Maori women.

Maori outcomes: expectations of mental health services.

Lorna Dyall; Geoff Bridgman; Anaru Bidois; Henare Gurney; Jenny Hawira; Phyllis Tangitu; Wi Huata.
Social Policy Journal of New Zealand, July 1999, 12:71-90.

Provides a broad overview of Māori expectations of mental health services in light of the growing number of Māori, both males and females, being admitted to in-patient and out-patient mental health care. Presents findings from research in progress based on a series of focus groups held in Rotorua in 1998, with different Māori stakeholder groups. Considers the implications for social policy.

Mental health and Maori development.

Durie M
Australian & New Zealand Journal of Psychiatry. 33(1):5-12, 1999 Feb.

The objective of this paper is to illustrate trends in Maori health, examine earlier health policies and to suggest avenues for improved mental health.

Several sources of historical and contemporary data have been reviewed and there has been some analysis of mental health policies as they relate to Maori. The interplay between culture, socioeconomic circumstances and personal health has been used as a context within which strategic directions are discussed.

Five strategies are highlighted: the promotion of a secure cultural identity, active Maori participation in society and the economy, improved mental health services, workforce development, autonomy and control. It is recommended that mental health services should be more closely aligned with primary health care, Maori youth, Maori-centred frameworks, and evidence-based practices.

Improvements in Maori mental health require broad approaches which are consistent with Maori aspirations and coordinated across the range of sectoral and disciplinary interests. Active Maori participation in the process and the retention of a cultural base will be critical if the current trends are to be reversed.

Breast cancer is more common in Maori than in non-Maori women under the age of 40 years and is equally common in older women, despite Maori being generally of lower socioeconomic status and having had a higher fertility rate than non-Maori.

Long-term benefits for Maori of an asthma self-management program in a Maori community which takes a partnership approach.

M.M. Ratima, C. Fox, B. Fox, H. TeKaru, T. Gemmell, T. Slater, W.J. D'Souza and N.E. Pearce
Australian and New Zealand Journal of Public Health, Dec 1999, 23(6): 601-5

In 1991, an intervention trial of the efficacy of an asthma self-management plan was carried out in partnership with a rural Māori community. The program relied on Maori community health workers and other health professionals working in partnership, was delivered through clinics in traditional Maori community centres and Maori processes were followed throughout. The plan was shown to be effective in reducing asthma morbidity. Objective: To assess whether the long-term benefits of the program extend beyond reduced asthma morbidity and the extent to which any additional benefits may be related to the partnership approach employed by the program. Method: Forty-seven (68%) of the original program participants were surveyed in August 1997. Participants were questioned on the program's impact in areas such as cultural development, health service access and lifestyle. Results: In addition to the improvements in asthma morbidity, the program was found to have four key benefits: cultural affirmation; improved access to other health services; a greater sense of control for participants; and positive impacts on the extended family. Conclusions: The program's benefits extended beyond reduced asthma morbidity and were not due simply to the introduction of the asthma self-management plan but also to the partnership approach employed by the program. Implications: The study provides support for providing public health services for indigenous communities that take a partnership approach, utilise community expertise and are delivered in a way that is consistent with each community's cultural processes.

The study provides support for providing public health services for indigenous communities that take a partnership approach, utilise community expertise and are delivered in a way that is consistent with each community's cultural processes.

The Māori SIDS Prevention Programme : challenges and implications for Māori health service development

David Tipene-Leach; Sally Abel; Riripeti Haretuku; Carole Everard
Social Policy Journal of New Zealand, Jul 2000; 14:65-77

Traces the development of the Māori SIDS Prevention Programme to date. Addresses the issues it has faced and the implications of these issues both for its own programme development and for Māori health service development in general. Overviews the context of social and health service changes within which the programme developed. Describes

the development of the programme, in terms of both contractual arrangements and interventions. Discusses key challenges faced by the programme, with particular regard to the changing health service structures and the differing demands of the health purchaser and the Māori community. Considers possible future directions for the programme and its workforce and looks at the implications of the issues raised for Māori health service and workforce development.

Reorienting family services: the professional response to sudden unexpected deaths in infancy — issues and protocols.

David Tipene-Leach; Sally Abel; Carole Everard; Riripeti Haretuku.
Social Policy Journal of New Zealand, Dec 2000, 15:27-40

This paper discusses key service and support issues faced by families who have experienced a sudden unexplained death of an infant (SUDI), the majority of which are from sudden infant death syndrome (SIDS), within an environment of increasing social inequality and poor service coordination. The issues include: changes in the social and economic environments of SUDI families; the forensic focus

of the professional response to a SUDI, inadequate training, audit and interagency coordination of key service agencies; and poor data collection for review and for tracking trends. The paper also discusses strategies developed by the Maori SIDS Prevention Programme (MSPP) team to

address these issues. These include the development, in consultation with key players, of an integrated and holistic national SUDI death scene protocol with regional teams that facilitate the coordination of services at the local level. In addition, a child mortality review process is advocated. These issues and proposed strategies potentially have relevance to families facing other difficulties that require the support and/or involvement of a number of government and other agencies.

Asthma morbidity 6 yrs after an effective asthma self-management programme in a Maori community

D'Souza WJ. Slater T. Fox C. Fox B. TeKaru H. Gemmell T. Ratima MM. Pearce NE. Beasley RB.
European Respiratory Journal. 15(3):464-9, 2000 Mar.

A 6-month Maori community-based asthma self-management programme, involving a "credit card" asthma self-management plan, has previously been shown to be an effective and acceptable system for reducing asthma mor-

idity The effectiveness of the asthma self-management programme and participants' self-management behaviour was assessed 6 yrs after the formal end of the programme. Participants were surveyed at the time of enrollment, and 1, 2, and 6 yrs after completing the programme. In each survey, participants were questioned on markers of asthma morbidity and use of medical services during the previous 12 months. Self-management behaviour was assessed using a questionnaire at 2 years and 6 yrs. Of the 69 original participants, 47 (68%) were surveyed after 6 yrs. They generally had reduced severe asthma morbidity and emergency use of health services from baseline. In particular, the proportion who had an emergency visit to a general practitioner had decreased from 41% to 18% ($p=0.02$). However, the percentage of nights woken due to asthma had returned to preintervention levels, and the proportion of participants taking prescribed regular inhaled steroid had decreased from 91% to 53% ($p<0.001$). Compared with 2 yrs after completion of the asthma programme, self-management behaviour had also deteriorated, with 29% versus 73% ($p<0.001$) using their peak flow meter daily when their asthma was "getting bad" and 41% versus 86% ($p<0.001$) using the "credit card" plan to increase the amount of inhaled steroids in the last year. Although the programme participants were still experiencing reduced morbidity from their asthma 6 yrs after the end of the self-management programme, the benefits were less than those observed at 2 yrs. These findings suggest that under-recognition and under-treatment of asthma with appropriate amounts of inhaled steroids is a major factor contributing to asthma morbidity in this indigenous rural community. To obtain enduring benefits from a self-management system of care continued reinforcement of self-management skills seems to be an essential component of any follow-up.

Public health strategies for Maori.

Durie M. (School of Maori Studies at Massey University, Palmerston North)
Health Education & Behavior. 27(3):288-95, 2000 Jun.

When the New Zealand Department of Public Health was established in 1900, Maori health status was compromised to the extent that survival itself was threatened. The remarkable turnaround was unexpected and owes much to pioneer Maori professionals, especially the first Maori medical practitioner, Dr. Maui Pomare, who graduated in the United States in 1899. As "Medical Officer to the Maoris," and later as Minister of Health, he made major changes through a five-part strategy: recognizing Maori community leaders as leaders in health, improving access to societal goods and serv-

ices (especially housing and education), appealing to cultural practices that were linked to good health, wise use of political power, and developing a skilled Maori health workforce to complement community leadership. Although mental health disorders and lifestyle illnesses have largely replaced infectious diseases, malnutrition, and tuberculosis, Pomare's strategy has continuing relevance and warrants serious consideration as a model for health promotion.

Ethnic differences in perceptions of body size in middle-aged European, Maori and Pacific people living in New Zealand.

Metcalf PA. Scragg RK. Willoughby P. Finau S. Tipene-Leach D.

International Journal of Obesity & Related Metabolic Disorders. 24(5):593-9, 2000 May.

OBJECTIVES: The aim of this study was to compare perceptions of body size in European, Maori and Pacific Islands people with measured body mass index (BMI), waist-to-hip ratio and change in BMI since age 21 y. Socio-demographic factors that influenced perceptions of body size were also investigated. DESIGN: Cross-sectional survey. METHODS: Participants were 5554 workers, aged ≥ 40 y, recruited from companies in New Zealand during 1988-1990. RESULTS: Prevalences of BMI >25 kg/m² were: Europeans, 64.7% men, 47.2%

Maori health status was compromised to the extent that survival itself was threatened. The remarkable turnaround was unexpected and owes much to pioneer Maori professionals, especially the first Maori medical practitioner, Dr. Maui Pomare, who graduated in the United States in 1899.

women; Maori, 93.2% men, 80.6% women; and Pacific Islanders, 94.1% men, 92.9% women. Similarly, prevalences of BMI >30 kg/m² were: Europeans, 14.4% men, 14.6% women; Maori, 55.0% men, 41.9% women; and Pacific Islanders, 55.1% men, 71.7% women. At each perception of body size category, Maori and Pacific Islands men and women had a higher BMI than European men and women, respectively. BMI increased with increasing perception of body size in all gender and ethnic groups. Since age 21, increases in BMI were highest in Pacific Islands people and increased with increasing perceptions of body size category in all ethnic and gender groups. BMI adjusted odds (95% CI) of being in a lower perception category for body size were 1.70 (1.38-2.12) in Maori and 8.99 (7.30-11.09) in Pacific people compared to Europeans, 1.27 (1.13-1.42) times higher for people with no tertiary education, 1.41 (1.25-1.59) times higher in people with low socioeconomic status, and 0.94 (0.92-0.95) for change in BMI since age 21. CONCLUSION: Nutritional programs aimed at reducing levels of obesity should be ethnic-specific, addressing food and health in the context of their culture, and also take into account the socioeconomic status of the group. On the population level, obesity reduction programs may be more beneficial if they are aimed at the maintenance of weight at age 21.