Pacific Health Review

Making Education Easy

Issue 20 – 2014

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Welcome to Pacific Health Review.

Whilst there have been improvements in some areas of health for Pacific people such as immunisation, particularly HPV, the health of Pacific women of reproductive age is an area of concern. In this edition we cover research presented at the TAHA & Whakawhetu conference in June 2013.

We know that Pacific women are less likely to prioritise their needs above the needs of their children and families and that may contribute to the concern. However, the high rate of Pacific teenage pregnancies suggests that a greater focus on younger women who are less likely to access health or more likely to disengage with maternity services is critical.

Finally, on another note, perhaps just as important as the research findings, is the amazing wealth of knowledge and skill we have in the Pacific health experts who have provided comments for this issue. All these young Pacific women represent a growing generation of health professionals who are spearheading the changes we now see in the health sector. It is inevitable that they will contribute to the change through their passion and commitment to ensuring better health outcomes for all Pacific peoples.

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Pacific Health Review – Pacific Maternal & Infant Health

Main points from TAHA & Whakawhetu conference:

- The presentations are a sample of the diversity of issues during pregnancy and infancy.
- Most studies showed that environmental exposures during pregnancy and infancy have a significant impact on health outcomes.
- Some studies not only show high rates of negative outcomes or risk factors, but reflect the persistence of these rates.
- We are only scratching the surface of a very innate topic, particularly for a vulnerable, high-needs population group.
- Teenage births in NZ and the younger demographic of parents within the Pacific population calls for a youth focus in policy, funding, planning, health promotion, healthcare and workforce development.
- Most recommendations called for cultural competency and cultural appropriateness in the various responses required to address pregnancy and parenting issues.
- Providing continuity of care during pregnancy and early parenting is as essential as providing care that is respectful of a family's cultural and spiritual beliefs/practices. Care that is warm and non-judgmental is also a success factor when working with Pacific families.
- These studies/models reinforce the need for engaging well with Pacific families during pregnancy and early parenting, and delivering quality health promotion and quality healthcare and support.
- While there is growing political and social support for addressing maternal and infant health in NZ, we need to advocate for tailored and targeted initiatives that are developed and delivered within a cultural context, for Pacific families.
- More studies are needed and there should be on-going collation of information, and discussion of Pacific maternal and infant health issues.

Key points are provided by Jacinta Fa'alili-Fidow, TAHA (Well Pacific Mother and Infant Service), University of Auckland

Jacinta Fa'alili-Fidow is from Samoa and lives in Auckland. She is currently the Manager of TAHA Well Pacific Mother & Infant Service based at the University of Auckland. She has held roles in primary care quality coordination (Pasifika Healthcare, now called West Fono Trust), research processes and systems (Manager Pacific Health Research, Health Research Council) and policy, funding and planning (Portfolio Manager, Ministry of Health).

South-Pacific teenage births in New Zealand

Presenter: Seini Taufa

Summary: This presentation was part of a PhD thesis and explored the demography of teenage pregnant women in New Zealand and particularly their cultural/ethnic differences. Birth registration data from 44,768 teenage mothers from 1996 to 2011 were de-identified and analysed. Qualitative analysis was also undertaken during 2008 in the form of 21 semi-structured face-to-face interviews with Tongan teenage mothers in New Zealand and Tonga.

When prioritised ethnicity was used, Pacific teenage birth rates were intermediate between those of Māori and European women. When the Sole / Any Pacific classification was used, teenage births were significantly higher for the Any Pacific category compared with the Sole Pacific Category. By Island group, teenage birth rates were also significantly higher for Cook Island Māori and Niuean women than for Samoan or Tongan women. For all Pacific groups, teenage birth rates were higher for those living in the most socioeconomically deprived areas.

Comment (Dr Sainimere Boladuadua): Teenage pregnancy describes all pregnancies in teenage women including those that end in terminations, miscarriage, still birth or a live birth. New Zealand has one of the highest teenage pregnancy rates in the developed world, with teenage births (33.4 per 1000) being second only to the USA (55.6 per 1000). Teenage mothers and their babies are at increased risk of poor outcomes, which include poor educational achievement, poor physical and mental health, social isolation, poverty and related factors – key factors in widening existing health inequalities.

Pacific teenage pregnancy rates are three times higher than for European/Pakeha teenage pregnancy and this presentation showed that current ethnicity classifications underestimate the number of Pacific people that may be teenage mothers. Also not surprising was the finding of a positive association between teenage pregnancy and socioeconomic deprivation. It keeps being said that Pacific women in New Zealand are a heterogeneous group, with significant differences in teenage birth rates being evident for different Pacific groups. Despite this, their teenage pregnancy rates are still significantly higher than those for non-Māori non-Pacific women and a common theme across the different Pacific groups was exposure to significant socioeconomic deprivation. This has significant policy implications, if the ongoing wellbeing of these young mothers and their babies is to be ensured.

Furthermore, there is a need for improvement in the access to and cultural appropriateness of maternity services. As has been highlighted in the 'External Review of Maternity Care in the Counties Manukau District', there is a need to improve the access to and quality (including cultural appropriateness) of maternity services for Māori and Pacific women who have been identified to be more likely to experience perinatal death.

Dr Sainimere Boladuadua is a Public Health Medicine Registrar currently working at the Health & Disability Intelligence Unit at the Ministry of Health.

Smoking and the risk of SIDS

Presenter: Dr Edwin Mitchell

Summary: According to 52 studies completed before the "Back to Sleep" campaigns, the risk of Sudden Infant Death Syndrome (SIDS or cot death) associated with maternal smoking during pregnancy showed an increased risk (Pooled OR 2.9; 95% CI 2.8 to 3.0). Similarly, the more cigarettes pregnant mothers smoked, the greater the risk for SIDS. Reducing maternal smoking from 20+ cigarettes per day to 10–19 per day lowers the risk of SIDS by 25%, while getting those who smoke 1–9/day to stop lowers their risk by 75%. A number of epidemiological studies (at least 17) published since the "Back to Sleep" campaigns have revealed that the risk associated with maternal smoking increased significantly by nearly 4-fold (Pooled OR 3.9; 95% CI 3.8 to 4.1).

The risk of SIDS is increased with the father smoking where the mother is a non-smoker (Pooled OR 1.5; 95% CI 1.2 to 1.8). Similar studies have shown that the risk of SIDS from bed sharing is especially high in those infants who are under 3 months of age. In addition to this, Vennemann et al. (2005) identified other risk factors for SUDI such as the presence of both bed sharing and maternal smoking, which increase the risk of SUDI by nearly 8-fold (Unadjusted OR 7.7; 34 cases vs 19 controls). However, when removing maternal smoking from bed sharing the risk reduced to just 2-fold (Unadjusted OR 2.0; 14 cases vs 70 controls). The more risk factors involved, the greater the impact on SUDI. Similar research that estimated the SIDS rate per 1000 live births for a low-risk group (mother aged 26–30 years second child, birth weight of 2500–3499g) revealed that the combination of babies bottle feeding and bed sharing in the presence of alcohol (both parents) is lethal (OR 27.5; Ratio of rates 16.0). Removing bed sharing from this combination reduces the risk (OR 1.77). In another example, bottle feeding babies that are bed sharing in a smoke free environment are at increased risk (OR 0.34; Ratio of rates 2.7). Removing bed sharing from this combination reduces the risk to 0.13 (Ratio of rates 2.7)

In terms of application to best practice, the message is loud and clear. If parents follow key SIDS prevention messages, the risk of SIDS is low.

Comment (Ana Liki-Vaimoli): According to the Ministry of Health (MOH), 60 babies in New Zealand die from SIDS every year. Professor Ed Mitchell's presentation clearly identified the common nationally and internationally recognised risk factors that contribute to SIDS, in particular maternal smoking, smoking exposure with bottle feeding and bed sharing. SIDS, however, is modifiable and avoidable. For example, families need to be reminded that having the infant sleep in the bassinet/cot next to the parent's bed is the most risk-free decision to make and if they choose to bed share both intentionally and unintentionally they need to be aware of the risk involved. SIDS is not a disease or a rare disorder and the research evidence is loud and clear that smoking is a known risk for SIDS. Hence, the message is to normalise best practice evidence such as a) no bed sharing, b) no smoking during pregnancy c) provide a smoke free environment, d) back sleeping, e) and breast feeding will reduce the risk of SIDS.

It is a responsibility of all health professionals, legal and social services to deliver clear and consistent messages regarding SIDS prevention, so that we can learn from this evidence-based information and substantially reduce New Zealand's unacceptable SIDS toll. Health professionals also need be aware that most smokers want to quit smoking and maternal smoking is no exception. Strong evidence shows that delivering brief advice is effective at supporting smokers to quit. Information to reduce SIDS needs to be provided to families from the antenatal stage, at birth, the postnatal stage and with ongoing infant care. When delivering SIDS information, messages need to take into account the health literacy as well as the reality of the lives lived by families, particularly in deprived communities where SIDS risks cluster.

Ana Liki-Vaimoli is a Well Child Nurse and previously worked as a Pacific Plunket Nurse Educator. Ana sits on the Taha Advisory Group and provides input at a strategic level to the service.

Smoking during pregnancy: New Zealand distribution and relevance for SUDI prevention

Presenter: Dr Liz Craig

Summary/Comment (Pauline Sanders-Telfer): This presentation gave an overview of national data collected for the years 2009–2010. I have reviewed this presentation based on the abstract and slides.

At the time of delivery, most women are registered with a Lead Maternity Carer (LMC) (83%). Mothers not registered with a Lead Maternity Carer (LMC) at delivery were under 24 years of age, in the most deprived (NZDep 9–10) areas (27%), with the largest group being of Pacific ethnicity (39.6%). Babies born to mothers who smoked at first registration with a LMC were likely to be under 24 years of age, Māori and live in decile 9–10 areas. The data on sudden unexpected death in infancy (SUDI) in infants by age could have included the percentage of deaths from women in the high-risk groups to add a confirmatory dimension to the data. The risk factors for SUDI between 2004–2008 reflect the 2009–2010 data. Sadly, these have not changed in 10 years.

Observations of the information are:

- there is an overwhelming number of women in the high-risk groups, who smoke and are registered with a LMC. Further investigation into why smoking is so prevalent with women who are engaged with a LMC is required, including the identification of where the opportunities are to improve the rate of smoking cessation;
- there is an over-representation of low early engagement of maternal care for Pacific women – early engagement can also positively influence the incidence of SUDI, and in this group, other health issues can also be addressed;
- there is an absence of clear expectations for local boards to have targeted programmes with specific measures required to improve the outcomes for Māori and Pacific women and babies.

The most obvious concern is that the risk factors and outcomes have not changed in 10 years; therefore, an alternative, innovative and creative strategy is required. The outcomes highlight the fact that locally-driven initiatives are not significantly impacting the health of at-risk women and babies. A Ministry-driven requirement for District Health Boards to include a strategy for addressing this issue may assist in moving the outcomes in a positive direction. This has shown improvements and motivation to change in other areas of health where inequity is overwhelming.

Pauline Sanders-Telfer is Project Manager in the Strategic Programme Management Office at Counties Manukau DHB.

The impact of overweight and obesity on pregnancy – how can we improve outcomes for mother and baby?

Presenter: Professor Lesley McCowan

Summary: Professor McCowan's talk highlighted the fact that excessive gestational weight gain with postpartum weight retention is an important contributing factor to the obesity epidemic in women and is independently associated with a range of pregnancy complications including large-for-gestational-age infants, increased Caesarean delivery, hypertensive disorders of pregnancy and possibly diabetes in pregnancy.

Improving maternal nutrition and limiting gestational weight gain have been linked to improved outcomes for mothers and babies. In a recent meta-analysis of randomised dietary and lifestyle interventions in pregnancy, nutritional interventions were found to reduce gestational weight gain by approximately 4 kg, substantially reduce the risk of gestational diabetes and preeclampsia and were associated with a trend to reduced stillbirths. Exercise interventions alone reduced weight gain by approximately 1 kg and were associated with small reductions in birth weight. Data are awaited from 2 large international randomised studies of lifestyle interventions in obese pregnant women. Professor McCowan made the point that interventions that prove successful in other settings may not be transferable to South Auckland's multicultural community. Local researchers are therefore seeking funding for a large randomised controlled trial of a culturally appropriate, affordable and sustainable nutritional intervention in overweight and obese pregnant women in Counties Manukau. It is hoped that the findings may help to reduce the vicious cycle of obesity on the unborn baby.

Comment (Dr Josephine Aumea Herman): The complications of obesity in pregnancy are well established and sobering, given that 85% of our Counties Manukau Pacific mothers are considered overweight or obese during pregnancy. Large studies conducted outside New Zealand have produced relatively good results around lifestyle interventions. In general, Pacific populations are poorly represented in intervention studies, so the proposed randomised control trial is well positioned to provide us with critical information that could determine what may or may not assist in achieving study objectives.

While this study focuses on the Counties Manukau context, it plays a critical role in broadening our knowledge base on improving Pacific pregnancy and infant outcomes. Importantly, study results could help identify solutions potentially applicable to Pacific women and families in the wider Auckland region, New Zealand, and the Pacific region; a setting with a population of 10 million Pacific people with high health needs, but comparatively poorly resourced.

Prenatal and early life environment and the risk of later obesity

Presenter: Associate Professor Paul Hofman

Summary: This presentation described the growing awareness of the importance of prenatal and early life environment in relation to the risk of later obesity. Recent data were discussed on the beneficial impact of maternal exercise during pregnancy in limiting fetal growth and potentially reducing postnatal obesity.

Comment (Dr Josephine Aumea Herman): This presentation highlights the ongoing vulnerability of our Pacific babies and children. We know from the Pacific Islands Families study that, in general, we have large babies and even for those who are born small or premature, by four years of age at least one-quarter of our Pacific children are considered obese.

Our Pacific mothers and children are growing up in increasingly obesogenic environments, a situation that requires focussed attention on addressing evolving cultural beliefs and norms around healthier food and nutrition practices. The role of physical activity is possibly under-exploited, given the high number of Pacific people's representation in national sporting codes, who are potential role models to drive effective school- and community-based programmes.

When there is political will, the Pacific community could potentially reverse this obesity epidemic. For our pregnant mothers, we could start with replacing the traditional 'eating for two' practice with 'walking for two' (or three in the case of twin pregnancies).

Dr Josephine Aumea Herman is from the Cook Islands, and is a public health specialist with broad experience and knowledge of health systems and workforce development in the Pacific region, particularly strengthened during her role as Cook Islands Ministry of Health (2007-09); Director of Community Health Services and Acting Director Clinical Health Services.

Continuity of care and carer: What is it about my model of continuity of midwifery care that supports safe and positive birthing journeys for Pacifica women

Presenter: Adrian Priday

Summary/Comment (Dr Ausaga Tanuvasa): This presentation by Ady Priday, an independent midwife, provides a successful model of midwifery practice that could be applied to other midwifery services nationally, based around the author's experience of midwifery practice for nearly two decades. The strengths of the model are based on integration of woman-centred and family, being informed by the five key elements of cultural competency, continuity of care, informed consent, the midwife as navigator and advocate, and respecting the woman and family's cultural and spiritual ways. The presentation suggests that this approach works well for Pacific women and family if the midwife upholds all the key elements that develop trust and open communication between the midwife, woman and family.

Adrian believes that continuity of midwifery care for vulnerable communities such as Pacific mothers and family will see positive health gains far beyond the current pregnancy.

Dr Ausaga Faasalele Tanuvasa joined the Health Services Research Centre (HSRC) in February 2007. Ausaga previously worked as a Senior Lecturer at Tertiary Education. She has held senior positions for a number of health services and has been a consultant and advisor to government departments, including NZAID and ACC.

Taha Pacific Maternal and Infant Health Conference 2013

Keynote Speaker: Dr Karaponi Okesene-Gafa

Summary/Comment (Gerardine Clifford-Lidstone): This important presentation by Dr Kara Okesene-Gafa provides information about research she undertook to understand barriers to antenatal care for pregnant women in the Counties Manukau District.

In December 2013, the Ministry of Health published the NZ fetal and infant deaths data for 2010. The findings show that Pacific people had the highest fetal death rate in 2010 at 9.8 deaths per 1000 (compared to 8.0 per 1000 for Māori and 6.4 per 1000 for 'other' ethnic groups). In addition, the Pacific infant death rate (8.0 per 1000) was nearly twice that of 'other' ethnic groups (4.4 per 1000).

Based on the 2011 population projects from Statistics New Zealand, nearly 40% of New Zealand's Pacific population reside within the Counties Manukau District Health Board boundaries. In the Counties Manukau District, the combined fetal and infant death rate for Pacific peoples was 18.4 per 1000. This compares to 12.9 per 1000 for Māori and 8.9 per 1000 for 'other' ethnicities.

Clearly, there is an on-going challenge to address disparities in child and maternity health.

Recently (October 2013), Pacific Perspectives completed a qualitative research project, working alongside Counties Manukau District Health Board to seek the specific views of young people, teenagers, Māori, Pacific and vulnerable mothers. We interviewed 61 mothers who had birthed at Middlemore Hospital or one of the Primary Birthing Units in Papakura and Botany Downs.

Our findings support Dr Okesene-Gafa's research and when reviewing her findings a few things particularly stood out for me. According to Dr Okesene-Gafa, one of the highest predictors of late booking was fear of Child, Youth and Family Service. While this may seem unusual to some, many of the teenaged and young mothers who participated in the Pacific Perspectives research project indicated they had previously been under the care and protection of Child, Youth and Family for a period of time as children. The trauma and fear resulting from this experience creates significant barriers for these mothers to engage with the mainstream system in any shape or form.

Another finding from Dr Okesene-Gafa is the need to engage aiga, kopu tangata, vuvale, magafaoa, aiga, fāmili, kāiga, in the maternity care process. The Pacific Perspectives research confirms that many young people, teenagers, Māori, Pacific and vulnerable mothers are highly dependent on other family members for transport to get to appointments, meals, childcare, health literacy and to support navigating the complex maternity care system. If these family members do not have the right information, it is difficult for them to provide appropriate support and pass on information that is accurate.

There is one issue that does not feature strongly in this presentation, although is alluded to in aspects of it such as workforce development and it emerged very strongly in our qualitative research. Firstly, young, teenaged and vulnerable mothers in Counties Manukau continue to face significant negative stigma from health professionals. This is characterised by extremely poor service experiences and results in these mothers disengaging from the maternity care system entirely, cherry picking the services they want, when they want it and becoming highly defiant and confrontational with those who they perceive as treating them poorly or unfairly. The challenge is ensure health professionals have a better understanding of the world views of young, teenaged and vulnerable mothers, so that they stay engaged.

Gerardine Clifford-Lidstone is Senior Consultant at Pacific Perspectives. Gerardine has held senior roles within the public sector and was formerly the Chief Executive Officer of a Pacific social service and health provider.

Alcohol and pregnancy don't mix

Presenter: Metua Bates

Summary/Comment (Associate Professor Nicolette Sheridan): Metua Bates, a senior advisor Pacific for the Health Promotion Agency, delivered a compelling presentation on the risks of alcohol consumption in pregnancy at the 'Tapuaki 1st New Zealand Pacific Maternal and Infant Health Conference' held on 20 June 2013 at the Holiday Inn, Auckland. She is a registered nurse and has a master of Business Administration. Of Cook Island and Tahitian descent, she was a founding member of the Cook Islands Nurses Association (NZ). In recent years, she has held executive posts with Pacific Health & Welfare, P.A.C.I.F.I.C.A. and the Cook Islands Health Network Association (NZ) and has maintained a longstanding commitment to reducing the harmful use of alcohol in Pacific communities.

Bates began her talk by defining the mandated role of the Health Promotion Agency (HPA), a Crown entity established under the New Zealand Public Health and Disability Amendment Act of 2012, as one that must lead and support the promotion of health and wellbeing. She identified a focus on healthy lifestyles and the prevention of disease, illness and injury within the broader context of reducing social and economic harm. The HPA's alcohol-specific functions – advice and research – were explained with advice targeting the sale, supply, consumption, misuse and harm of alcohol and research focusing on public attitudes and the use, problems and consequences of alcohol misuse. Describing children as treasures and the birth of a baby as a family blessing – Tapuaki, she went on to identify the long-term impacts on families when alcohol consumption leads to miscarriage, stillbirth, and fetal alcohol spectrum disorder (FASD), giving a personal account of the difficulties a family faced when a child had FASD.

Bates' central point, "*There is no known safe level of alcohol use at any stage of pregnancy*" was followed by a key primary prevention message, "*Stop drinking when pregnant or when planning a pregnancy*". She reported that one-fifth of Pacific women consume alcohol when pregnant and that they were less likely than NZ European and Māori women to have been advised against this. Advocating for the *Ask, Advise, Assist* approach, and sharing with her audience practical resources available in multiple languages to Pacific women, she concluded a strong address on a health concern of high importance.

Dr Nicolette Sheridan is an Associate Professor of Nursing at the University of Auckland's School of Nursing. Nicolette has extensive clinical experience in primary health care environments and has previously worked as an advisor and consultant.