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Kia orana, Fakaalofa lahi atu, Talofa lava, Malo e lelei, Bula vinaka, Taloha ni, Kia ora, Greetings.

Welcome to this edition of Pacific Health Review.

The articles and commentaries address aspects of the complex question facing many developed countries about why minority, ethnic, culturally and linguistically distinct groups do not get the services they need. At the centre of the challenges and debates is the issue of Pacific identity and how it is defined.

Two Wellington-based studies highlight the need for ethnic-specific approaches, exploring the differences between ethnic groups that are included in the umbrella term Pacific. A focus on families, migration and socioeconomic issues are discussed in the research regarding Pacific children with obesity, while the Counties Manukau Health research with young people suggests that 'youth' is the defining characteristic. Jacinta Fa'alili, in her reviews of research into Vitamin D and depression in pregnant women, notes that the link between ethnicity and Vitamin D has a physiological basis (skin colour), whereas the association of ethnicity and depression must be about sociocultural factors and not genetics. These discussions and debates are a welcome sign that as a sector we are moving on from trying to get Pacific health policy and research on the table by identifying the "Pacific problem" in health to having the more critical, nuanced discussions about the pathways and processes that lead to disparities in health outcomes for Pacific people. An understanding of these issues is central to the responses we choose.

Thank you to all our reviewers. We welcome your feedback.

Matafanua Hilda Fa'asalele

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Pacific ethnic groups and frequent hospital presentation: A fair target?

Author: Irvine Z

Summary: This audit discusses data from a case series of children that were ever seen at the Kenepuru Accident and Medical Clinic (KAMC), a 24-hour walk-in clinic in a community hospital in Porirua, New Zealand. At the time of the audit, the children were aged 0–5 years. Ethnicity analyses revealed that among all children ever seen at KAMC, Samoan ethnicity was associated with the highest frequency of presentation (mean number 6.35), followed by Other Pacific (5.41), Cook Island Māori (4.73) and Māori (4.33). Non-Māori, non-Pacific ethnicity was associated with the lowest frequency of presentation (3.54). Similarly, among children resident in Porirua, Samoan ethnicity was associated with the highest frequency of presentation, most closely followed by Other Pacific; the lowest frequency of presentation was associated with non-Māori, non-Pacific ethnicity. When the analysis controlled for socioeconomic status, among children resident in NZDep10 suburbs (in the most deprived 10% of New Zealand), Samoan ethnicity was associated with the highest frequency of presentation, most closely followed by non-Māori, non-Pacific. The lowest frequency of presentation was in Cook Island and Māori ethnic groups. In this series, 23% of Samoan children were found to have presented ≥ 10 times since birth, compared with 15% of Cook Island children (OR 1.7; $p < 0.005$) and 12% of Māori children (OR 2.2; $p < 0.0001$).

Comment (Dr Corina Grey): This simple but thoughtful study, recognising that "Pacific people" is an umbrella term for several different groups, examined the mean number of presentations in 0–5-year-olds to a 24-hour A+M clinic in a community hospital. Cook Island Māori children had a similar mean number of presentations as Māori (approximately 5 per year), whereas Samoan youngsters presented, on average, 7 times a year. The mean number of presentations was 3.5 for non-Māori non-Pacific children.

The fact that Samoan children presented more frequently than all other ethnic groups suggests that somehow primary care is not meeting their needs. As these children were younger than 6 years, finances should not have been a barrier to care, but appointment availability, proximity to care, and parental understanding of the role of general practice may have been salient factors. This study is an important first step in identifying ways to improve primary care use and access for Pacific people in the Porirua area. Next steps are to identify the reasons behind the high rates of A+M presentations and develop culturally appropriate ways to address barriers to primary care and attitudes towards health service use.

Reference: *Emerg Med Australas.* 2016;28(3):357-9

Abstract

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Acceptability and non-compliance in a family-led weight-management programme for obese Pacific children

Authors: Teevale T et al.

Summary: These researchers sought to determine what factors influence both participant retention and attrition in a family-led weight-management programme for obese Pacific children in New Zealand. Semi-structured face-to-face interviews were conducted with 42 parents/primary caregivers of obese children participating in the weight-management programme. Interviews were held at exit and end of the 8-week intervention. The data analysis identified four key themes that enhanced retention: (1) simultaneous delivery of the programme to both children and parents as participants; (2) having trustworthy and accountable relationships among programme personnel and between participants; (3) location of venues and receiving financial support to travel to programme venues; and (4) receiving regular telephone/text messaging follow-up calls reinforcing programme goals and supportive personal home visits. Suggested future programme improvements included having ethnic-specific Island-language delivery and practical sessions like cooking classes and healthy food shopping expeditions. Reasons for non-completion included unpredictable external life crises such as extended family deaths, a change in job shift, family illnesses (both acute and those requiring chronic management) and long-term family visitations. A loss of momentum through managing life crises was often difficult to overcome for participants, leading them to drop out of the weight-management programme. Most drop-out participants preferred to defer their programme participation with hopes of re-committing to future programmes at another time.

Comment (Sameli Tongalea): The article is about a research project that focused on a weight-management programme involving families with children with obesity and the follow-up provided to those families who did not complete the entire programme. It identified the most common barriers for disengagement from self-management programmes. The feedback from participating families can provide some insight into the future design of self-management programmes for Pasifika families, especially if every suggestion made by participating families, irrespective of whether they completed the whole eight weeks or not, is taken into consideration. Of particular interest was the number of female participants (grandmothers, aunts, mothers) who were island-born, the number of families from multi-ethnic households, those in two-parent families and those families in employment. In considering these key characteristics of the participating family groups, it may be worthwhile for future Pasifika family-focused groups to consider what influence these factors (either individually or collectively) had on the families' decisions to complete the programme or not. Food for thought...

Reference: *Public Health Nutr.* 2015;18(14):2625-33

[Abstract](#)

An innovative community organizing campaign to improve mental health and wellbeing among Pacific Island youth in South Auckland, New Zealand

Authors: Han H et al.

Summary: Handle the Jandal (HtJ) is a community organising youth-led campaign (by youth, for youth) supported by Ko Awatea and aimed at building youth resilience to improve mental health and wellbeing. Ko Awatea is embedded within Counties Manukau District Health Board and has a mandate to lead an innovative approach to achieving sustainable, high-quality healthcare services. Counties Manukau Health conducted interviews, focus groups and pre- and post-campaign surveys to examine changes among 30 Pacific Island young people who had taken part in the HtJ campaign. Ten youths completed both pre- and post-campaign surveys. Eleven youths participated in focus groups, and four in interviews. Overall, youths reported an increased sense of agency and improvements to their mental health.

Comment (Dr Jemaima Tiatia-Seath): This paper presents preliminary data on the 'Handle the Jandal' youth campaign, a programme aimed at helping Pacific youth navigate their way through the challenges of coping with pressure. It is an innovative Counties Manukau Health designed initiative which began in 2011, employing a community organisation strategy as a means to improving the mental health and wellbeing of Pacific youth.

Pre- and post- surveys, complemented by focus groups and interviews with programme leaders and recruits, were undertaken to measure the efficacy of this strategy in improving personal agency and mental health outcomes for South Auckland Pacific youth from low-income families. The authors acknowledge that their small sample size (up to 30 participants) has its limitations, however, these findings do much to contribute to a scant evidence base concerning Pacific youth, mental health and wellbeing.

It is pleasing that an evaluation of this type was conducted, not only to measure the programme's impact, but also to actively disseminate quality-assured Pacific youth-focused evidence. Indeed, it is an important contribution to Pacific youth health and wellbeing.

The study found that youth involved in the Handle the Jandal initiative reported an increased sense of agency, however some youth reported declines in understanding their moods and feelings as well as being liked by their peers. The authors interpreted this as a sign of engaging with the challenges of organising as navigating uncertainty requires development of new skills, which can be associated with emergence of emotional setbacks. Other findings that showed personal growth and achievement of goals supported this interpretation.

The findings demonstrate that an organising strategy has the potential to be used as a preventative approach in improving mental health wellbeing among 'disempowered' communities. A strength of the community organisation strategy approach is that it derives from within the community and is community-owned and driven. Counties Manukau Health did extremely well to put this in to action.

Reference: *Australas Psychiatry.* 2015;23(6):670-4

[Abstract](#)

Culturally and linguistically diverse patients' views of multimorbidity and general practice care

Authors: McKinlay E et al.

Summary/Comment (Api Talemaitoga): This is very relevant NZ research. Patients with multimorbidity (MM) were recruited from the diabetes register of a Very Low Cost Access (VLCA) general practice. Emphasis was placed on recruiting research participants known to have low English proficiency (LEP). The research included 10 culturally and linguistically diverse (CALD) patients (5 males, 5 females) from 3 ethnic groups – Samoan, Cook Island Māori and Cambodian. Strengths of this research are: presenting the perspective of the patient as compared to previous research that focused on the views of clinicians; and use of research methods to systematically capture the perspectives and worldviews of patients with LEP. Language-specific focus groups and interviews were facilitated by trained interpreters in a 'purposeful' way, using alternative language/terms as required to convey the real meaning of the interview question and to translate the participant's responses. This ensured the nuances of the interview questions were understood and that the research participants were able to answer and express their thoughts in their own language.

The researchers reported 5 main themes: (1) Patients expressed confusion and a lack of understanding about their conditions. Health professionals did not spend enough time explaining their conditions and medications to them and did not use language-specific resources. 2) Patients had specific beliefs about how their bodies functioned and the impact of both MM and medications prescribed, which if not addressed were likely barriers to understanding clinician explanations about their conditions and adherence to medication. 3) Effects of MM on health, and the patient's functional ability to work. Medications used to treat MM were not well understood and medications were not taken as intended. Inadequate explanations about MM and possible medication side effects meant CALD patients would alter medication regimes on their own, in response to their experience of side effects. (4) Self-care management – patients acknowledged the role they had to play in their own care. The lived reality for CALD patients with MM was clear and disheartening. Patients struggled with MM and the impact of their conditions on paid employment, for example, patients working multiple jobs or shift work struggled to find the time to access healthcare, take medications and manage other aspects of their illness. (5) General Practice Care. Responses were mixed, with some happy to see a doctor and/or nurse and others stating that they preferred to see only a doctor. It was not clear whether this meant a GP or a hospital specialist (based at the Practice).

The findings of this research align with international evidence that CALD patients often receive lower quality care with regard to access; screening for disease and risk factors; and communication. The authors also cite international evidence that describes how culture, language and beliefs about health and illness impact on health-seeking behaviour, health literacy, health expectations and patient management.

This article provides a wealth of information for clinicians working with CALD patients and especially those with MM. It goes beyond the usual description of the determinants of health to address the 'determinants of the determinants': lack of understanding of MM; patient's individual beliefs; clinician's failure to adequately explain how medications work, interactions and side effects and how the medication can help their MM. Another very important finding is the involvement of family for CALD patients with MM. The authors have also shown the importance of the availability and use of interpreters in their research. This has helped them to gather rich data – a key lesson for any health professional working with CALD patients.

Reference: *J Prim Health Care*. 2015;7(3):228-35

[Abstract](#)

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Depression symptoms during pregnancy: Evidence from *Growing Up in New Zealand*

Authors: Waldie KE et al.

Summary: These researchers explored maternal characteristics associated with antenatal depression in an ethnically and socioeconomically diverse sample of 5,664 pregnant women living in New Zealand who completed a face-to-face interview during the third trimester while participating in the *Growing Up in New Zealand* study. Symptoms of antenatal depression were assessed using the Edinburgh Postnatal Depression Scale (EPDS), which identified 672 (11.9%) participants who had EPDS scores (13+) that indicated probable antenatal depression.

Comment (Jacinta Fa'alili-Fidow): The *Growing Up in New Zealand Study* (GUINZ) is undoubtedly a treasure among the small group of longitudinal studies ever conducted in New Zealand. Besides the Pacific Islands Families Study, GUINZ has a significant Pacific cohort from across Auckland and Waikato. Approximately 7,000 pregnant women were recruited to the study and of these, 5,664 pregnant women completed a face-to-face interview that included measurements for antenatal depression using the EPDS and collection of other information such as perceived general health, maternal stress, family cohesion and neighbourhood support. The study found significant differences in antenatal depression between different ethnic groups. Pacific women were twice as likely to suffer from antenatal depression as measured by the EPDS scale, as compared with those of European ethnicity. In fact, Asian and other ethnicities showed antenatal depression rates similar to Pacific women, leading the researchers to conclude that ethnicity is 'associated with a greater likelihood' of depression during pregnancy. This type of conclusion is very unfortunate as I'm sure the researchers did not mean to infer that because you are of non-European ethnicity that your genetics determine your state of mental wellbeing. There are certainly clinical diagnoses that don't have clear causal pathways and the research explicitly outlines limitations of the study, namely recall bias and measurement error. I am not questioning the accuracy of the data that the researchers have used to show ethnicity as an independent risk, but there needs to be consideration of other unmeasured factors, including cultural and societal factors that make up the complex nature of mental wellbeing. Buried deep in the body of the paper is a cautionary note about the need to validate the EPDS scale for antenatal use with Māori, Pacific or Asian (as has been done with postnatal depression by Ekeroma AJ et al. [N Z Med J. 2012;125\(1355\):41-9](#)). But blink and you'll miss it. Such are the limitations of this approach to research and the conclusions that result. There is increasing recognition of the need for research approaches that provide understanding of the worldviews and lived realities of mothers and families that address important issues such as trust and engagement with health services. What is certainly true is that further attention is required for supporting women during pregnancy, especially when the association between a mother's mental health status has been proven to have a real impact upon the life course of her child. But these can only be properly addressed if we know what is really going on with 'ethnicity'.

Reference: *J Affect Disord.* 2015;186:66-73

[Abstract](#)

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Predictors of vitamin D status in pregnant women in New Zealand

Authors: Ekeroma AJ et al.

Summary: Vitamin D deficiency (serum 25-hydroxyvitamin D (25(OH)D) concentration <50 nmol/L) is common in New Zealand. For instance, in a sample of over 900 healthy newborns born in Christchurch and Wellington between 1997 and 2001, 350 (57%) were vitamin D-deficient. These researchers aimed to identify and quantify risk factors associated with vitamin D deficiency in an ethnically diverse sample of 259 pregnant women in New Zealand recruited from a community maternity clinic in South Auckland. All women had serum 25(OH)D concentration measured at 27 weeks gestation. A total of 109 (42%) women were found to be vitamin D-deficient. Enrolment season and ethnicity were independently and significantly associated with the odds of vitamin D deficiency, whereas sunlight exposure and dietary vitamin D intake were not. Of those enrolled in winter (June-August)/spring (September-November), vitamin D deficiency was present in 43% of European, 67% of Māori, 80% of Pacific and 59% of women of other ethnic groups.

Comment (Jacinta Fa'alili-Fidow): Vitamin D deficiency resurfaces every so often at forums or in the press as a neglected issue and one of growing concern. A recent survey of paediatricians identified 58 cases of rickets (Wheeler et al. 2015) among children in New Zealand. While the verdict is still out on the impacts of vitamin D deficiency on maternal and neonatal outcomes, correlations have been shown between maternal vitamin D status and that of the newborn. This study sought to highlight the high prevalence of vitamin D deficiency among pregnant women in an ethnically diverse population in Auckland. Of 259 pregnant women recruited, 42% were vitamin D-deficient. Ethnicity and enrolment sessions were found to be independently associated with the odds of vitamin D deficiency. Unlike other studies that have found associations between ethnicity and risk factors, a clear physiological explanation for the ethnicity risk is available through the evolution of pigmentation and the role of melanin in skin. As vitamin D is produced by the skin following exposure to the sun and UVB rays, melanin in darker skin protects against UVB and therefore darker-skinned individuals must have more exposure to the sun than lighter-skinned individuals. Exposure to sunlight is obviously easier in summer than winter, hence the seasonal variation, however, the researchers propose universal distribution of vitamin D supplements to counter the high prevalence. The Ministry of Health policy regarding vitamin D describes high-risk individuals as: those who have darker skin; completely avoid sun exposure; have liver or kidney disease; are on certain medications (e.g. anticonvulsants); or if one lives south of Nelson-Marlborough in winter. The Ministry recommends sun exposure before 10am and after 4pm in Spring/Summer and middle of the day during winter, and eating vitamin D-rich foods such as fatty fish (e.g. canned salmon, tuna or sardines); eggs; liver (but don't eat more than 100 g per week); some margarines, milks and yoghurts. Midwives and GPs are currently able to prescribe vitamin D supplementation if screening identifies severe levels of deficiency but the researchers of this study believe that current policy potentially misses 42% of vitamin D-deficient pregnant women. It is an unfortunate issue that fights for the limelight compared to more well-known supplements during pregnancy such as folic acid, iron and iodine, however, greater awareness is important in a society of sunscreens and rainy seasons.

Reference: *N Z Med J.* 2015;128(1422):24-34

[Abstract](#)

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The distribution and frequency of blood lipid testing by sociodemographic status among adults in Auckland, New Zealand

Authors: Exeter DJ et al.

Summary: In this study, population-based patterns of blood lipid testing were examined by sociodemographic status among adults residing in the Auckland Region of New Zealand. Nationally held datasets (primary care enrolment, laboratory tests, pharmaceuticals, hospitalisations and mortality) were linked anonymously to identify adults aged ≥ 25 years without cardiovascular disease or diabetes who had their lipids tested in 2006–2010. Age, gender, ethnicity, area of residence and area-level deprivation were obtained for each person. Of the 627,907 participants included in this study, 415,992 people (66.3%) had at least one lipid test between 2006 and 2010. Annual testing increased from 24.7% in 2006 to 35.1% in 2010. Lipid test frequency increased linearly by age in a similar fashion for men and women. Indian people were 87% more likely than New Zealand European and Others (NZE0) to be tested, Pacific people 8% more likely, but rates for Māori were similar to NZEO. There was marked variation within the region, with residents of the most deprived areas less likely to be tested than residents in least deprived areas.

Comment (Dr Corina Grey): This is an interesting study that examined lipid testing in ≥ 25 year olds without a history of cardiovascular disease (CVD) or diabetes in Auckland between 2006 and 2010. The authors reported that, after controlling for age, gender and deprivation, Pacific people had an 8% greater odds of having at least one lipid series test than New Zealand European/Other people. However, due to limited clinical information on the study subjects, the authors were unable to stratify results by estimated CVD risk, and it is likely that the distribution of CVD risk in Pacific (and Māori) people was higher than Europeans of the same age and gender. Therefore, based on clinical indication, it is likely that testing among Pacific people should have been even higher.

In 2012, two years after the end of this study period, the government introduced a national health target to increase the proportion of the eligible population receiving CVD risk assessments. It would be useful to know how lipid testing, and particularly the pattern of lipid testing among ethnic groups, changed as a result. According to Ministry of Health reports, approximately 90% of the eligible population have received a risk assessment in the last five years. Risk assessment (including lipid testing) is an essential first step to managing CVD risk in our population. We must therefore ensure that those who have not yet had a risk assessment receive one, and that everyone whose CVD risk is estimated is appropriately managed – whether it be with simple lifestyle advice, pharmacotherapy, or other measures.

Reference: *J Prim Health Care.* 2015;7(3):182-91

[Abstract](#)

Prevalence and recent trends in overweight, obesity, and severe obesity among New Zealand adolescents

Authors: Utter J et al.

Summary: This study examined the prevalence of, and recent trends in, overweight, obesity, and severe obesity among adolescents in New Zealand. Two nationally representative health and well-being surveys were conducted in 2007 and 2012, involving more than 17,000 secondary school students. The survey also included measured heights and weights. In 2012, nearly 40% of adolescents in New Zealand were overweight, obese, or severely obese. From 2007 to 2012, there were no changes in prevalence of overweight, obesity, or severe obesity for the general population, or for any demographic subgroup. However, prevalence of obesity and severe obesity increased significantly among Pacific young people from 27% in 2007 to 34% in 2012 ($p=0.02$). The prevalence of severe obesity increased among Pacific young people from 9% in 2007 to 14% in 2012 ($p=0.02$).

Comment (Dr Corina Grey): This study adds to an increasing body of work demonstrating how significant a problem obesity is in our Pacific communities. Two out of every three Pacific students in this study (compared to less than one in three European students) met the criteria for overweight, obesity or severe obesity. Furthermore, the Pacific ethnic group was the only group to experience a rise in the prevalence of obesity and severe obesity between 2007 and 2012, and now one in every three Pacific high school students is either obese or severely obese. As the authors point out, studies have shown that approximately 90% of obese adolescents continue to be obese as adults.

The fact that the majority of Pacific students are overweight or obese indicates that this is not a problem that can be addressed through simple health education messages or an individualised programme targeting only high-risk individuals. A comprehensive systems approach is needed that addresses the obesogenic environment (in schools, at work and in the community) and encourages physical activity and healthy food choices. We all have a role to play in advocating for changes (for example, a tax on sugary soft drinks, better regulation of advertising to children, easy-to-understand food labelling systems). Primary care practitioners can be positive agents of change by measuring BMI at each visit and discussing with their patients the benefits of even small reductions in weight, such as lowering the risk of CVD and diabetes and improving overall quality of life.

Reference: *Child Obes.* 2015 Oct;11(5):585-9

[Abstract](#)

CONTRIBUTORS TO THIS ISSUE

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