



VAIKOLOA

Pacific Primary Health Care Treasures

Vai (water) is a symbol of 'life-source' and koloa (treasures) to share

¹ Pasifika Medical Association, Auckland, New Zealand

² Health Promotion Forum of New Zealand, Auckland

³ Synergia Ltd, Auckland

⁴ School of Population Health, The University of Auckland, Auckland

J PRIM HEALTH CARE 2013;5(4):336–337.

CORRESPONDENCE TO:

Ofa Dewes

School of Population Health, The University of Auckland, PB 92019, Auckland, New Zealand
o.dewes@auckland.ac.nz

Responding to cellulitis in Pacific communities

Melitta Rigamoto BHSc, PGDip (Public Health);¹ **Ieti Lima** MA Hons, PhD;² **Adrian Field** MA Hons, PhD;³ **Ofa Dewes** MBA, PhD⁴

Cellulitis is a highly preventable bacterial skin infection commonly found in children, but it can also occur in other age groups.¹ If left untreated, the infection can lead to severe complications, causing disability or death.² In its severe stages, cellulitis requires hospitalisation for extensive surgical treatment.³

Hospital admission rates for cellulitis in New Zealand are twice that of Australia and the United States.³ Pacific people are at least 1.5 times more likely to have a diagnosis of cellulitis compared to the total population⁴ and Pacific children are over four times more likely than other children to be hospitalised for serious skin infections (within which cellulitis is grouped).⁵ Factors that contribute to the high rates of hospitalisation for skin infections, such as cellulitis, include the cost of primary health care and treatment,³ lack of understanding of the importance of early presentation,⁶ perception of skin infections being normal,^{6–8} and poor personal management and treatment of skin infections.⁶

There is limited research exploring the effectiveness of community-based interventions focused on reducing the incidence of cellulitis and other skin infections, and even less research in Pacific peoples. In New Zealand, some notable (but isolated) community-based projects have been undertaken in parts of Auckland and Wellington,^{3,7,9} including one specifically focused on Pacific communities.⁹

These projects utilised a range of strategies, from health promotion and disease prevention, to treatment and management of skin infections in primary health care. A key area of activity was collaboration with local health providers and public health nurses, as well as organisations outside of the health sector, such as Housing New Zealand, local government and ACC. The

projects took steps to address financial barriers to accessing primary health care, such as ACC or Primary Options Acute Care treatment. These projects often provided first aid resources, as well as information on basic hygiene and how to treat wounds. Other strategies focused on health promotion, including home visits, use of the media, community events, and church, sports club and school presentations.

Reduced rates of skin infections and/or improved early stage management of cellulitis were reported following implementation of these projects, but could not be directly attributed to their project activities. These findings nevertheless provide some indication of the potential of such community-based approaches. A key gap in these isolated pilot projects to date has been the absence of well-defined Pacific models of intervention, although in one project, active efforts were made to engage Pacific people through church-based activity.⁹ If cellulitis is to be effectively addressed in Pacific settings, the providers need to work directly with Pacific models that incorporate Pacific beliefs and values. These models highlight the importance of respect, relationships, the importance of working together and supporting one another, sharing of knowledge, as well as the importance that family, culture and spirituality have in everyday lives.^{10,11} Church-based approaches provide an important avenue, but not the only avenue, for health sector activity to address the health needs of Pacific people.^{12,13}

In Pacific families, cellulitis is often one health issue among many that they are dealing with, often including long-term conditions and their attendant impact. A key challenge is not to think of cellulitis as simply a single, treatable condition, but as part of ensuring integrated services to address the wider health care needs of Pacific people and their families.¹⁴

ACKNOWLEDGEMENTS

This commentary was informed by research funded by the Ministry of Health's Pacific Provider and Workforce Development Fund,⁹ in which three of the authors collaborated.

References

1. Eagle M. Understanding cellulitis of the lower limb. *Wound Essentials*. 2007;2:34–44.
2. Porter CJW, Simcock JW, MacKinnon CA. Necrotising fasciitis and cellulitis after traditional Samoan tattooing: case reports. *J Infect*. 2005;50:149–52.
3. Hunt D. Assessing and reducing the burden of serious skin infections in children and young people in the Greater Wellington Region. Six-month report January–July 2004 and update on progress. Capital and Coast District Health Board, Hutt Valley District Health Board and Regional Public Health; 2004.
4. Sopoaga F, Buckingham K, Paul C. Causes of excess hospitalisations among Pacific peoples in New Zealand: implications for primary care. *J Prim Health Care*. 2010;2(2):105–10.
5. Craig E, Jackson C, Han D. New Zealand Child and Youth Epidemiology Service Steering Committee. Monitoring the health of New Zealand children and young people: indicator handbook. Paediatric Society of New Zealand and the New Zealand Child and Youth Epidemiology Service, Auckland; 2007.
6. Ete-Rasch E. 'I thought it was just a pimple'. A study examining the parents of the Pacific children's understanding and management of skin infections in the home. Master of Arts (Applied) Thesis, Victoria University of Wellington, Wellington; 2009.
7. Morgan C, Selak V, Bullen C. Glen Innes Serious Skin Infection Prevention Project. Auckland: Auckland Regional Public Health Services; 2004.
8. O'Sullivan C, Baker MG. Serious skin infections in children: a review of admissions to Gisborne Hospital (2006–2007). *NZ Med J*. 2012;125(1351):55–69.
9. Jayasekera N, Field A, Rees D. Pacific community cellulitis services and oral health evaluation. Synergia Ltd. 2012.
10. Agnew F, Pulotu-Endemann FK, Robinson G, Suaalii-Sauni T, Warren H, Wheeler A, et al. Pacific models of mental health service delivery in New Zealand (PMMHSD) Project. Auckland: Ministry of Health, Health Research Council of New Zealand, Mental Health Commission; 2004.
11. Aitaoto N, Braun K, Dang K, So'a T. Cultural considerations in developing church based programs to reduce cancer health disparities among Samoans. *Ethn Health*. 2007;12(4):381–400.
12. Dewes OA. Obesity prevention in Pacific adolescents: is there a role for the church? Doctor of Philosophy in Population Health, The University of Auckland, Auckland; 2010.
13. Simmons D, Voyle JA, Fou F, Feo S, Leakehe L. Tale of two churches: differential impact of a church-based diabetes control programme among Pacific Islands people in New Zealand. *Diabet Med*. 2004;21(2):122–128.
14. Minister of Health and Minister of Pacific Island Affairs. 'Ala Mo'ui—Pathways to Pacific Health and Wellbeing 2010–2014. Wellington: Ministry of Health; 2010.

Fish oil for concentration in ADHD

Shane L Scahill BPharm, MMgt, PhD

There seems to be a groundswell in the use of fish oil in children with Attention Deficit Hyperactivity Disorder (ADHD) to improve concentration. Are there systematic reviews that support this practice?

SOME AVAILABLE BRANDS: Nutra-Life, Good Health, Thompson's, Nature's Own, Healtheries, Nordic Naturals, BioBalance, Ethical Nutrients, Clinicians, MICROgenics, Comvita, BioOrganics, Efamol, SANDERSON, Pro-Life, Deva Nutrition, Solgar.

ACTIVE CONSTITUENTS: Omega-3 fish oil (some Omega-3-6-9) with some preparations also containing glucosamine, vitamin D, red yeast rice, coenzyme Q10 and krill.

MANUFACTURER CLAIMS: The omega-3 nutrients eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) enhance quality of life and lower the risk of premature death. They have an important role in protecting and optimising nerve cell functioning. Conditions such as ADHD, autism, poor coordination, fatigue, dyslexia, and aggression all improve with omega-3 supplementation, as do a range of affective disorders, including depression and bipolar disorder. Cognitive function improves with sharper memory, clearer thinking and mental agility. In early stage Alzheimer's disease, omega-3 can slow down the rate

of decline, and supplementation may protect against onset of the condition. Optimal skin health, blood circulation and heart function, immune response and allergies are other indications for omega-3 fish oils.

EVIDENCE FOR EFFICACY: A search for fish oil and ADHD appears in two citations in the Cochrane Register of Controlled Trials (Central). One is in the adult population and includes olive and flax oil. The focus of this study is on raising levels of fish oil in the body, based on an assumption that fish oil is positively correlated with neuropsychiatric health. The second is a placebo-controlled double-blind trial in children with ADHD (N=40). This study is interesting in that the intake was through foods rich in fish oil, rather than a prescribed dose/number of capsules. Attention deficit, hyperactivity and impulsivity; aggression; visual perception; development of visual-motor integration; impatience did not significantly differ between groups. The authors conclude that intake of fish oil-rich foods did not improve ADHD-related symptoms. Although treatment of ADHD with fatty acids deserves further investigation, careful attention should be paid to which fatty acid(s) is used.

There are no Cochrane Reviews on this topic. However, a systematic review published in 2011 by Bloch and Qawasmi

Herbal medicines are a popular health care choice, but few have been tested to contemporary standards. **POTION OR POISON?** summarises the evidence for the potential benefits and possible harms of well-known herbal medicines.