EDITORIAL

Sudden unexpected death in infancy (SUDI) in New Zealand: discussion over the last 5 years and where to from here?
Suzanne Pitama, Cameron Lacey, Tania Huria

The incidence rates and risk factors of SUDI (inclusive of SIDS) have over the years been explored and discussed within the *New Zealand Medical Journal*. Moreover, the acknowledgement of Māori health disparities within SUDI has been the focus of many articles over the past 5 years.

In 2010, Tipene-Leach, Hutchison, Tangiora, Rea, White, Stewart and Mitchell\(^1\) presented an article on SIDS-related knowledge and infant care practices among Māori mothers. The authors utilised a cohort of Māori mothers in the Counties Manukau District Health Board area (south of Auckland) and through a survey—which had been completed previously in 2005 with largely a NZ European sample—explored SIDs-related knowledge and infant care practices. They found their Māori participants had higher rates of maternal smoking, ceased breastfeeding earlier than the NZ European cohort and were more likely to be a mother who practised bedsharing with her baby. These findings lead them to challenge the then SIDS-health promotion strategy and its relevance to a population highly effected by SIDS. They argued that in order for equitable health outcomes for Māori there needed to be a tailored approach to Māori (and those working with Māori) and recommended the inclusion of Māori medium and messages in future health promotion and health education material.

Baker and Uggs in 2011\(^2\) discussed in an editorial the use of SUDI as “an umbrella term used to describe a heterogeneous group of infants under age one who die without warning signs or distress sufficient to alert parents and caregivers” (pg 9). They advocated that in order to reduce SUDI incidents more health information was needed to be delivered within the antenatal environment. The authors pointed out their concern over perceived low health literacy levels in Māori families and those of low socioeconomic families. They specifically identified that health messages needed to account for the multiple stressors that Māori families were more likely to be exposed to. They also noted that “simple provision of information is a poor mechanism for change; efforts are needed to support engagement with innovative and culturally appropriate behaviour modification approaches as well as addressing the determinants of deprivation” (pg 11).

In 2012, Mitchell and Blair\(^3\) in their viewpoint article discussed their concerns about how SIDs prevention could be better in New Zealand, noting New Zealand’s extremely high rates of SIDS compared to other developed countries. They identified the design and development of flax-woven *wahakura* (‘waha’ to carry, ‘kura’ precious little object) and ‘pēpi-pods’ (a plastic wahakura) that were being utilised in response to provide safe sleeping spaces for babies. However, noted that no research had been undertaken to determine whether such devices assisted in the reduction of deaths.

Later, in 2013 Able and Tipene-Leach\(^4\) in a further viewpoint article documented the development of the wahakura, discussing its emergence in 2006 in Gisborne, and described that it usually was 72×34cm and woven from *harakeke* (flax). It was given to mothers with a thick mattress and a set of rules that outlined SUDI health promotion guidelines. The wahakura had emerged from Māori health workers in the field of SUDI who wanted Māori parents to keep babies safe when bedsharing, in a way that aligned with cultural beliefs and values. They highlighted a project evaluation which was able to map the future pathway for wahakura and how they could be sustained within future practice. This resulted in two pathways, firstly a study where participants were randomised to either a wahakura or bassinet and then the safety and benefits of each was explored (yet to be published). Secondly the use of a cheaper alternative developed by Nicola McDonald, the pēpi-pod was described. They concluded that with the use of wahakura and/or pēpi-pods a counter-narrative emerged, that
bedsharing was acceptable when the baby had their own safe sleeping space that was defined by the wahakura/pēpi-pod.

In 2015, Elder⁵ provided an editorial on the need to continue to improve New Zealand’s response to SUDI. Elder reiterated recommendations of how to reduce risk of SUDI, and identified that traditional bedsharing practice was usually in loci of a low sleep surface (often the ground or on mattresses) and with each individual having their own bed covering, which was in contrast to contemporary bedsharing environments. Elder did not identify how this might be navigated today within a health promotion or health education forum.

Elder’s editorial introduced the article from Hutchison, Thompson and Mitchell⁶ that reported on infant care practices related to SUDI from a 2013 survey. This survey randomly selected 400 women who had infants between 6 weeks and 4 months old, in Auckland to participate in a postal questionnaire, of which they compared their findings to a similar survey conducted in 2005.

Hutchinson, Thompson and Mitchell (2015) documented that there was an overall increase in maternal knowledge of SUDI risk factors between the two cohorts, in that mothers were less likely to position their infants in the supine position and room share, there was also a decrease in smoking and bedsharing. They concluded that an increase in maternal knowledge may be the reason for falling rates of SUDI. It was interesting to note in Hutchison et al (2015) article that only 13 (out of 172) respondents identified as Māori, and that their findings reflected mainly a NZ European sample and was not representative of the overall New Zealand population, and was not able to discuss specific issues for Māori SUDI rates.

As outlined, previous articles have reiterated the known risk factors of SUDI, the growing trend of the reduction of SUDI incidents within non-Māori communities and the need for more tailored health promotion and health education for Māori. The articles have identified the need for increased Māori whānau (extended family) awareness of SUDI, and the development of appropriate SUDI interventions that are deemed ‘acceptable’ by Māori whānau, hapu and iwi (tribal entities). It is this concept of exploring an ‘acceptable’ SUDI intervention that is presented within this edition of the New Zealand Medical Journal.

Abel, Stockdale-Frost, Rolls and Tipene-Leach⁷ document their ongoing work in the field of SUDI prevention within Māori communities. They utilise qualitative methods to explore experiences of Māori mothers who have utilised the wahakura and community stakeholders who had a working knowledge of the wahakura production or use. Their article provides clear evidence on the acceptability of this SUDI intervention which has ‘cultural currency.’ This article provides a template for the role of medical science in supporting community driven Māori health initiatives.

The partnership between the researchers and the community to utilise research methods to document evidence-based practice within Māori health is an exemplar for health research. In that, it has taken an area of health inequity, implemented a culturally relevant intervention, measured the intervention and applied it to ‘usual’ clinical practice. It stands as a model that Māori health inequities should drive research agendas and that when done well have the ability to change health outcomes (including acceptability).

The culturally-significant and appropriate wahakura is a health intervention example that should encourage health researchers and practitioners to work in partnership to develop evidenced-based interventions that address Māori health inequities.
Competing interests: Nil.

Author information: Suzanne Pitama, Associate Dean Māori, Māori/Indigenous Health Institute, University of Otago, Christchurch (and NZMJ Subeditor); Cameron Lacey, Senior Lecturer, Māori/Indigenous Health Institute, University of Otago, Christchurch; Tania Huria, Senior Lecturer, Māori/Indigenous Health Institute, University of Otago, Christchurch

Correspondence: Dr Suzanne Pitama, MIHI (Māori/Indigenous Health Institute), School of Medicine and Health Sciences, University of Otago Christchurch, PO Box 4345, Christchurch, New Zealand.
suzanne.pitama@otago.ac.nz

References


