Tuhia mai, whiua atu: Research and Methodology. Moderator - Professor Ngahuia Te Awekotuku

Serendipity, Shot-gun, Strategic: Does it make a difference?

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Kaupapa Māori research methodology demands practical outcomes of tangible benefit to Māori. This paper reflects on the steps taken to ensure benefit resulted from my PhD research, and I ask where is that benefit now?

Ensuring benefit starts before the project begins when the idea is conceived. Thus, I first reflect back to the birth of the idea. Then the consultation undertaken, and the conduct of the research, is reviewed with a utilisation focus. The personal costs of undertaking research are then considered in the sections looking at contribution and career. Finally, the question from the title of this paper is posed. Examples of the barriers to strategic action, such as, competition and the difficulty of achieving consensus are presented. Finally, the consequences of the research are outlined.

Conception

The idea for my PhD research, on the cessation of Māori smoking behaviour, germinated in the early 90s when I worked as a Policy Analyst for the Public Health Commission. While there I had the opportunity to analyse the state of Māori public health. I learned that tobacco use is the largest preventable cause of illness and death among all New Zealanders, with Māori being disproportionately affected. At that time there were many gaps in the NZ tobacco control programme. The biggest of them being that were no no-smoking cessation services purchased by Government.

Consultation

Having identified a knowledge and service gap, and that research would be needed to support advocacy for smoking cessation, I formulated a research focus and began to 'consult' with people on the idea. Consultation started quite informally, simply discussing the research topic and methodology with key stakeholders. For example, mentors, tobacco control advocates, Māori health advocates, potential academic supervisors, Māori health workers, and colleagues. Having canvassed these people and found support for the project, and for me to undertake the study as PhD research, I began to pursue the formalities of applying to the University for entry to the PhD programme, and to the Health Research Council for funding. I also sought formal support, in the form of a letter, from Māori health organisations with which I could associate the research with.

Conduct

The development of relationships with end-user groups served several objectives. These organisations gave a kind of pseudo hapu/iwi approval to the project being conducted within their rohe. They gave access to research participants and the programmes that were to be evaluated. They assisted with recruitment, participant retention, and follow-up. They provided comment on draft chapters and/or findings. Ultimately, they awaited the results and were ready to take up the knowledge derived from the research and implement it in their practice.

Earning the support of such groups and maintaining that support is dependent upon the quality, and thus the integrity, of the relationship formed between the researcher and the community. Kanohi kitea, that is, being seen, is an important form of

communication that allows people the opportunity to observe the researcher in practice. The community assesses a person by their conduct in meetings, at hui, during kai, and by their contribution. This can occur from afar: just being seen at a hui, a tangi, a sports event is noted. It is very difficult to provide communities with opportunities to assess you if you don't turn up and contribute. The study was started in the mid 90s and took the rest of the decade to complete.

Contribution

However, academic study can create a vacuum that sucks researchers into 'the ivory tower'. To combat this, I maintained an active involvement in the tobacco control and auahi kore communities, via my board membership of Apārangi Tautoko Auahi Kore (the Māori Smokefree Coalition), memberships of the New Zealand Psychological Society and the Public Health Association, and via attendance at relevant hui and conferences.

Before the study was even completed I was called upon by the Health Funding Authority to give advice on the development of tobacco control policy and smoking cessation programme development. I contributed to the development of service specifications for the now successful Aukati Kai Paipa programme, a Māori smoking cessation programme delivered by 35 providers throughout New Zealand. I was then contracted to write and deliver training in smoking cessation for the programme. During the 2 years that I was contracted, over 70 Aukati Kai Paipa 'coaches' were trained. A further 400 Māori community health workers have received training in brief smoking cessation through my work with Te Hotu Manawa Māori.

I am also a member of the New Zealand Smoking Cessation Guidelines Advisory Panel and the GlaxoSmithKline Zyban Advisory Panel. All these associations have facilitated the dissemination of the knowledge gleaned throughout my PhD study and some have allowed for the practical passing on of the information, such as through the training of health workers.

Unfortunately, because I have focused on kanohi ki te kanohi forms of dissemination, my record of publication is less spectacular. Further, opportunities for publishing in peer reviewed journals in New Zealand are limited and the prospect of wasting time competing for entry into international journals has been off-putting. These forms of dissemination, whilst highly regarded by academia, are less accessible and relevant to Māori communities. I acknowledge however, that there are a growing number of academically trained Māori and Māori students within academia who would make use of such sources.

Career

Sometimes the most important outcome is the development of people, which in turn ensures the development of whānau, hapu, and iwi. In a culture with an oral tradition, individual people were the repositories for knowledge. Everyone did not need to be expert in all things. Thus, a responsibility remains to protect, and thus maintain, the knowledge gained, and to pass it on to those who will use it well. Dissemination is an ongoing process. For years after initial dissemination, people will go to the person holding the knowledge for the information they need, rather than going to the library.

Conundrum

Was the extent to which the PhD results have been used, to impact upon New Zealand Tobacco Control and smoking cessation for Māori, serendipitous? In 1993, Māori tobacco control advocates began lobbying for smoking cessation services (PHC, 1994). Meanwhile, our Pākehā counterparts argued against us. It wasn't until the New Zealand delegation to the 10th World Conference on Tobacco or Health (in 1997) were told that smoking cessation should be at the top of their agenda did we advocate as one and finally gain Government support. If researchers overseas had not first proved that treatment for nicotine dependency was indeed cheaper than treatment for blood pressure, even the worldwide tobacco control movement (and Treasury) might not have capitulated.

Competition

Whether we are trying to address Pākehā dominance (politely termed Māori development), violence, or smoking, competition is rife. The competition of ideas is the critical one. Each person and faction of the tobacco control movement (and this applies equally to every movement) has a different analysis of the problem and how to intervene. So, we talk "comprehensive strategy" but we fight over the crumbs that get flicked our way.

Consensus

If a strategic approach is the answer, why does the arena of Māori health research look like we're at a child's birthday party playing pin-the-tail-on-the-donkey, or running around on a treasure hunt without clues?

I am also a member of the Health Research Council Māori Health Committee and have sat on two Assessing Committees. The Health Research Council (HRC) funds researcher-initiated projects. That is, researchers apply to the HRC for funding for projects they have conceived, rather than tendering to conduct research conceived by the purchaser of the research. The Health Research Council also uses peers to review and grade applications using a set of numerical scales that purport to favour scientific merit. As psychologists, you all know how vulnerable these kinds of measurement tools are.

From my experience, very few applications reference any strategic direction in providing rationale for their study. Perhaps choosing a research topic is a highly personal and subjective experience: to commit to a project for an extended period you need to have a genuine passion for the topic, plus the pay as a researcher is not attractive. That is, we do it for the kaupapa not the money.

The current research funding environment leaves it up to researchers to direct our progress forward. Where is the overall analysis? The meta-analysis that rises above individual agendas? There are so many gaps in our Māori knowledge base, and so many problems to solve – perhaps we will have as much effect blasting our shot-gun in the general direction of a better future?

But, if we don't prioritise, can we progress? I am also Chair of the Tobacco Control Research Strategy Steering Group. Following a recent consultation exercise to write our strategy document, we tried to prioritise the long list of research topics identified as a need. We applied numerical grading criteria then plotted the results on a graph and ended up with a blob: everything was a priority!

Consequence

So I've just put 10 years into tobacco control and where are we now? No, I didn't have to make an impact on tobacco use by Māori on my own, though in 1993 when I was appointed National Co-ordinator Māori Smokefree at Te Hotu Manawa Māori, I was the first paid Māori dedicated to work on auahi kore fulltime. Now we have a sizeable Māori auahi kore workforce.

Although Māori smokers smoke fewer cigarettes per day than a decade ago, the number that smoke remains the same: still nearly half of Māori adults (over the age 15) smoke. Many have quit, but just as many have started or restarted. As a community we are in the early days of learning just how addictive nicotine is, of learning how to quit, and how to prevent relapse. There appears to be progress, more smokefree homes, more smokefree marae, and a greater acceptance of smokefree environments: but the prevalence statistics resist change.

Year after year, only one or two researchers apply to the Health Research Council for projects that might impact on smoking. Then only some of them have been funded. "Peers" all have different ideas about what's a priority. The single largest preventable cause of illness and death in New Zealand and one of the top contributors to the burden of disease worldwide, is not seen as a priority!

Conclusion

In this paper I have outlined the presumably strategic approach to choosing a PhD research topic, carrying out the research, and disseminating the results to ensure practical benefit to Māori: as required when using a Kaupapa Māori research methodology. New interventions

have been influenced by the research. There has been a contribution to workforce development and the development of the Māori health knowledge base. But, Māori smoking prevalence has not changed – yet.

I have drawn on my work experience to question the national approach to community development and change. I want to argue that our research should be guided by some national over-arching strategic direction, but I acknowledge that accidental and ad-hoc changes also contribute, though I am unconvinced if they are resulting in progress.

We lack an infrastructure that can support strategic planning, consensus development, promotion of a strategic direction, and co-ordination of the implementation of strategies. In Māori health research, or the tobacco control research arena, that's things like regular bulletins, journals, hui, consensus development workshops or conferences, sufficient and secure funding for researchers and research centres, having easy access to the existing literature, any process for monitoring and accountability, and having and maintaining international linkages. Leadership and vision at a Ministerial level is missing.

The current environment relies too heavily on the individual, and thus supports the dominance of non-Māori individualistic cultures. To redress this, we must look to institutionalise, within our work and research environments, the processes and infrastructures that support a whānau, hapu, and iwi based culture.

References

Public Health Commission. (1994). *Māori Smokefree Hui Report*. Wellington: Public Health Commission.