DEVELOPING A KAUPAPA MĀORI RESEARCH PROJECT TO HELP REDUCE HEALTH DISPARITIES EXPERIENCED BY YOUNG MĀORI WOMEN AND THEIR BABIES

Beverley Lawton*
Fiona Cram†
Charrissa Makowharemahihi‡
Tina Ngata§
Bridget Robson¶
Selina Brown**
Warahi Campbell††

Abstract

Young Māori mothers experience stigma and their babies experience poor health outcomes. Interventions to reduce these health disparities need to understand the lives of these young women.

* Associate Professor, Women’s Health Research Centre, University of Otago, Wellington, New Zealand. Email: Bev.lawton@otago.ac.nz
† Director, Katoa Ltd., Auckland, New Zealand. Email: fionac@katoa.net.nz
‡ Research Fellow, University of Otago, Wellington, New Zealand. Email: Charrissa.Makowharemahihi@otago.ac.nz
§ Assistant Research Fellow, University of Otago, Wellington, New Zealand. Email: Tina.ngata@otago.ac.nz
¶ Associate Dean Māori, Eru Pōmare Māori Health Research Centre, University of Otago, Wellington, New Zealand. Email: Bridget.robson@otago.ac.nz
** Senior Research Nurse, Women’s Health Research Centre, University of Otago, Wellington, New Zealand. Email: Selina.brown@otago.ac.nz
†† Kaumātua, Women’s Health Research Centre, University of Otago, Wellington, New Zealand. Email: Selina.brown@otago.ac.nz
This paper describes consultation to seek agreement for research with young Māori mothers to be conducted in two regions. Consultation occurred with tribal authorities, Māori health providers, district health boards, and community stakeholders. Endorsement was gained for strength-based research with young pregnant Māori women and their babies. The research also includes service provider interviews, and analysis of policy. Project oversight is by three advisory groups: Māori elders, young Māori mothers, and an academic group. Community feedback occurs throughout the project. Consultation is an ongoing process conducted within a relationship context. It enhances the development, implementation and translation of research that seeks to represent the lives of those who are vulnerable, and eliminate health disparities.

Keywords
Māori health research, community consultation, Māori health disparities, teenage pregnancy, young Māori mothers

Introduction

Young Māori mothers experience the stigma of being Māori and being teenage mothers. Their babies also experience poorer health outcomes than non-Māori. Interventions to reduce these health disparities need to have a comprehensive understanding of the lives of these young women, including the challenges they face, their aspirations, and their support networks.

This paper describes a community-up process in which Māori researchers engaged with Māori communities for feedback about, and permissions for, a research project looking at the journeys of young, pregnant Māori women. A background to Māori reclamation of research is followed by an overview of the health disparities experienced by Māori babies and young Māori mothers. A third section provides an overview of the consultation process. This is followed by a discussion. The purpose of this paper is to highlight the roles of Māori researchers undertaking research that is by, with, and for Māori, and the importance of research processes that respect relationships and the aspirations communities have for wellbeing.

Reclamation of Māori research space

Until recently, Māori experiences of research have been largely about non-Māori researchers conducting deficit-based research on Māori (Smith, 1999). A little over 20 years ago Ngahuia Te Awekotuku’s (1991) guide for how ethical policy-related research could be undertaken represented a growing Māori voice that Māori expected to be consulted about research that should be both with and for us if it was going to be valid and truly about us. Te Awekotuku wrote about the sacred nature of Māori knowledge and the regulations that operated in ancient Māori society to control access to knowledge. The arrival of Pākehā (non-Māori) missionaries in the 1800s introduced written literacy skills into Māori society and, with them, new possibilities for the recording of and access to previously restricted knowledge. With this development came the ethical question: “To whom, and for whom, should this taonga [treasure] of recorded knowledge be of most benefit?” (Te Awekotuku, 1991, p. 8).

While Māori were grappling with issues of access to knowledge, Pākehā were recording knowledge from their encounters with Māori. Throughout the 19th and 20th centuries Pākehā scholars dominated anthropological and related
research fields and were aggressive authors of published works about Māori (Smith, 1999; Te Awekotuku, 1991). In spite of several Māori academics emerging in the 1960s, published Māori knowledge and the standard-setting for validating ways of knowing about Māori remained firmly in the hands of Pākehā. For example, Ranginui Walker described Māori education as “a hunting ground of [Pākehā] academics as neophytes cut their teeth on the hapless Maori. Maori are in the subordinate position with little or no social power to keep out the prying Pakehas” (Walker, 1985, p. 231). There have been exceptions among non-Māori researchers—Te Awekotuku names James Ritchie and Ann Salmond—who have had long-term relationships with Māori mentors and Māori communities. These researchers established “culturally intelligible and acceptable frames of reference” for undertaking research and provided examples of how research can be responsive to Māori (Stewart & Williams, 1992, p. 2).

Māori are not anti-research; we have always been researchers and have welcomed non-Māori who work in respectful ways (Reid, 1999). However, opening our lands to newcomers disrupted Māori knowledge systems, and research was often used by colonial forces to justify the oppression of Māori (Smith, 2006; Walker, 2004). The bad name research has within Māori communities is not about the notion of research itself; rather, it is about how that research has been practised, by whom, and for what purpose that has created ill-feeling.

Over the past 20–30 years the efforts of research disciplines and research funders to become more culturally responsive have increased (Cram, 1997). In health, the Health Research Council (HRC) first published guidelines in 1996 for health researchers wishing to undertake Māori health research, and revised these in 2008 (Health Research Council, 2008). Applicants for HRC funding are required to demonstrate how their research is responsive to Māori by documenting consultation processes, community permissions, and commitments to building Māori research capacity. In other parts of the world (e.g., Australia, Canada) protocols and guidelines for research with Indigenous peoples have also been released by funding agencies and by Indigenous peoples themselves (e.g., Assembly of First Nations, 2012). These stress the importance of principles such as respect and reciprocity, the importance of elders and cultural and spiritual protocols, the role of mutual understandings and power sharing, allowing for the time and space it takes for good relationships to develop and flourish, and aspiring to cultural revitalization (Wilson, 2008; World Health Organization, 1997).

The re-invigoration of Māori research was greatly enriched by the 1999 publication of Linda Smith’s seminal book Decolonizing Methodologies. Māori researchers are now leading research and in some cases, as foretold by Ranginui Walker in 1990, asking our Pākehā colleagues to act as advisors or consultants to our research (Cram & Phillips, 2012; Walker, 2004). According to the World Health Organization (1997, p. 10) Māori are not the only Indigenous group experiencing a surge in research capacity and its consequences.

What remains steadfast for Māori across these developments are the responsibilities to the iwi (tribe(s)) involved in the research that were documented by Te Awekotuku (1991, pp. 17–18):

- A researcher’s responsibility to the people of the iwi transcends all other responsibilities.
- A researcher must acknowledge and protect the interests, rights and
sensibilities of research participants.
- The aims of any investigation are to be explained clearly, with people having the right to full and informed consent.
- Researchers must not use the information they gain for personal gain or aggrandisement.

An expression of these responsibilities is embodied within a Kaupapa Māori (a framework and way of working built on Māori world view) Research paradigm, and this is described next.

Kaupapa Māori Research paradigm

Throughout the 1990s and into the present day much research by Māori has been conducted within a Kaupapa Māori Research paradigm that firmly asserts the validity and legitimacy of Māori being Māori (Smith, 1997). As Pihama (2010, p. 5) writes, “The development of Kaupapa Māori as a foundation for theory and research has grown from Māori struggles for tino rangatiratanga [self-determination] and mana motuhake [autonomy]”. This move to decolonize research and theory occurred first in education and has since spread to other disciplines, including health, over the past 15–20 years.

A Kaupapa Māori Research paradigm allows us to acknowledge that the research we undertake as Māori researchers has a different ontological (i.e., theory about the nature of reality) and epistemological (i.e., theory of knowledge) foundation than Western-oriented research (Smith, 1999). The Māori world is whakapapa (genealogy), and it is through the process of whanaungatanga (relationships, kinships) that we know our world. Methodology (i.e., theory about how to find out things) is prescribed in cultural terms and makes moral and cultural sense (Durie, 1996; Te Awekotuku, 1991). Once the kaupapa (agenda) of the research is tika (true), then the priority for researchers is to find the right methods and the right people (Mead, 2003). Accountability for our research is primarily to our relations and, as such, we engage in research that addresses real issues so as to inform and promote real solutions that will facilitate Māori wellness.

The Assembly of First Nations (2012, p. 3) discusses the need for such a paradigm shift so that “mutually respectful dialogue processes” can be created and Aboriginal knowledge respected by researchers. Such a shift occurs when Indigenous peoples are treated as an equal party in the research and the process of researcher–community engagement and consultation is ongoing—from the development of research proposals through to the drafting of research reports and the advocacy for evidence-informed policy changes (Mik’maw College Institute, 1999). Community participation is key to ensuring that research is connecting with local needs and aspirations, and will therefore stand the best chance of being both valid and relevant (Kirkhart, 2005; World Health Organization, 1997). These practices for researchers engaging with Māori communities were promoted by Sporle and Koea (2004a, 2004b).

Consultation is undertaken within an historical context that includes the legacy of disparities now experienced by Māori. Māori communities are well aware that they are portrayed in government statistics as having poorer health, fewer educational qualifications, a higher rate of imprisonment, and a lower rate of employment (Te Puni Kökiri, 2000). Changing deficit-based perceptions of disparities analysis was greatly assisted by the Hauora: Māori Standards of Health volumes begun by Eru Pōmare and continued by Te Rōpū Rangahau Hauora a Eru Pōmare (Eru Pōmare Māori Health Research Centre), University of Otago, Wellington. When the fourth Hauora volume was published in 2007 (Robson & Harris, 2007), the lead authors conducted workshops on Kaupapa Māori epidemiology to increase Māori knowledge about disparities, including the interpretation of disparities within
a structural analysis that framed disparities as a failure of government to deliver on the citizenship promise of the Treaty of Waitangi (Reid & Cram, 2004).

Consultation between Māori health researchers and Māori communities about health research priorities has a dual focus on the elimination of disparities and the realization of cultural aspirations (Hawke’s Bay District Health Board & Ngāti Kahungunu Iwi Incorporated, 2011). Māori communities are concerned about health disparities; they see the implications of them in their day-to-day lives as people carry the burden of long-term conditions such as diabetes and heart disease at both a higher rate and a younger age than non-Māori (Curtis et al., 2010; Harwood & Tipene-Leach, 2007). Analysis of the determinants of these conditions includes an understanding of the barriers to accessing health services as well as the impact of behavioural, social, cultural and societal issues on Māori health (Signal, Martin, Cram, & Robson, 2008). This is paired with people’s aspirations to live good, healthy cultural lives such that the elimination of disparities is just one part of a bigger health equity picture that includes individuals, whānau (family), hapū (sub-tribe), and iwi (tribe) (Durie, 1994; Taskforce on Whānau-Centred Initiatives, 2010).

It was from this standpoint that we, a group of Māori health researchers supported by our kaumātua (elder), Warahi Campbell, and our non-Māori colleagues, embarked on an ongoing consultative relationship with two regions about a Māori health research project that we felt was needed to expand our understanding, beyond negative stereotypes, of the lived realities of young Māori women becoming pregnant, having their babies and becoming mothers.

**Why prioritize young Māori women and their babies?**

We chose to focus on pregnant Māori women under 20 years old as both local and international evidence suggests that being young and Māori is a risk for poor health outcomes for both mothers and their babies. A cohort study looking at over four million births in the United States showed that teenage first pregnancy (10–19 years old) was associated with increased mortality of babies before and after birth, low weight gain of the mother, and premature births (Chen, Wen, Fleming, Yang, & Walker, 2008). International studies have shown that teenage mothers are more likely to get depression and anxiety and have compromised antenatal health. Furthermore, young motherhood can adversely affect educational attainment, often resulting in long-term benefit dependency and poverty (Hallam, 2008).

As Māori have a young population age structure with 35% of the total Māori population aged under 15 years (Ministry of Health, 2010c), maternal and child health affects a significant proportion of our population. Māori women under the age of 20 years have high rates of pregnancy; in 2010 16.6% of Māori women giving birth were under the age of 20, compared to 4.8% of non-Māori (Ministry of Health, 2010b). Pregnant Māori women under 20 have consistently higher rates of infant mortality when compared to “Other” ethnicity (L. Neilson, Ministry of Health, personal communication, 2010). Māori women under the age of 20 years have high rates of pregnancy; in 2010 16.6% of Māori women giving birth were under the age of 20, compared to 4.8% of non-Māori (Ministry of Health, 2010b). Pregnant Māori women under 20 have consistently higher rates of infant mortality when compared to “Other” ethnicity (L. Neilson, Ministry of Health, personal communication, 2010). Māori have a higher rate of stillbirth and neonatal death overall, with Māori women under 20 identified as being at added risk (Perinatal and Maternal Mortality Review Committee, 2010). Compared to non-Māori, Māori infants are more likely to die in their first year of life, with 340 more infant deaths per 100,000 (Battin, McCowan, George-Haddad, & Thompson, 2007; Ministry of Health, 2010a; Robson & Harris, 2007). Māori infants are also more likely to have avoidable hospitalizations with gastroenteritis, skin...
infections and respiratory admissions (Robson & Harris, 2007).

The differences in infant mortality, respiratory hospitalizations and immunization rates between Māori and non-Māori cannot be explained solely by socio-economic status. In Aotearoa/New Zealand, “diseases of poverty” can be described as “diseases of colonisation and racism” (Robson, 2004). Racism, whether structural or interpersonal, affects health (Gee, Spencer, Chen, & Takeuchi, 2007), and there is growing evidence that Māori have less access to, or lower quality of, lifesaving and other treatments (Blakely, Fawcett, Hunt, & Wilson, 2006; Bramley, Hebert, Tuzzio, & Chassin, 2005). Harris found that Māori were more likely to report experiences of racism and concluded that racism contributed to Māori health losses and inequalities in health between Māori and non-Māori (Harris et al., 2006).

Māori are less likely to receive benefits such as the disability allowance that helps with costs involved with doctors, hospital entitlements, medicines, extra clothing and special food or travel. It is estimated that Māori children miss out on at least $5.8 million of potential assistance per annum (Howell & Hackwell, 2003). Financial barriers exist for children’s health with “cost” being the most frequently reported reason for not taking children to a general practitioner when necessary. Cost is a more frequently cited concern for Māori caregivers than for non-Māori (76% compared to 45%) (Te Puni Kōkiri, 2000).

This research does not frame pregnancies to Māori women under 20 as inherently problematic. Rather, it aims to examine and address the higher risks of poor health outcomes for Māori women under 20 and their infants. This includes the barriers and facilitators of appropriate health care and wellness, along with the legislative, regulatory, funding and social policy information that impact on both service delivery and pregnant Māori women under 20 and their infants. The potential for improving the health outcomes for this group is great, and our aim is for the current study to contribute to evidence-informed policy and practice to reduce health disparities. Next we describe the process of engaging with communities about the research.

**Initial consultations**

Informal discussions with Māori providers of maternity services, and with Māori and non-Māori staff at two district health boards (DHBs) and hospitals were held in the lead up to the initiation of the present study. These confirmed that the health disparities experienced by Māori infants, and by young Māori women having babies, were also of concern to them and that they would be interested in being consulted about, supporting, and being involved in our research. Informal discussions with a number of Māori women who had been mothers before they were 20 years old confirmed that the research was of interest, and that we would most likely be able to recruit young, pregnant Māori women and young mothers to participate in a study. It was on this basis that we worked up an outline for a qualitative study and took this out for community consultation in the two DHB regions. The selection of these two sites for the research included consideration of the nature of the regions (e.g., composition of urban/city, semi-rural, rural), as well as pre-existing relationships with Māori and non-Māori stakeholders.

The selection of the Hawke’s Bay DHB region reflected long-standing research relationships, as well as kinship relationships, between Māori members of the research team, Te Rōpū Rangahau Hauora a Eru Pōmare, and the local tribe, Ngāti Kahungunu. Over the past 20 years a number of collaborative research projects have been undertaken by Te Rōpū Rangahau Hauora a Eru Pōmare and Ngāti Kahungunu Iwi Incorporated (Keefe-Ormsby, 2008). The researchers also had strong links with Māori and non-Māori staff within the DHB, and
with Māori health providers in this region. The University of Otago campus in Wellington is located on the same site as the Wellington Hospital so this pre-existing relationship with Capital & Coast DHB was important for the selection of this DHB. In addition, Ngāti Toa, the local tribe, has a formal relationship with the University of Otago, with a Memorandum of Understanding in place since 2008. Some of the Māori researchers again had strong links with Ngāti Toa, as well as with Māori health providers and other stakeholders in the region.

A two-phase approach to the development and finalization of the research protocol enabled us to first visit with people to gauge their interest and their views. Once the project had received funding we were able to return to the regions to seek people’s feedback on a more detailed project plan. The second round of consultation also allowed us to cast our net wider within the regions and include people who had missed the initial consultation and/or who were more prepared to discuss the project with us once funding had been confirmed. In addition, the formation of three advisory groups to guide the project, along with ongoing discussion and consultation in and beyond the two regions, has secured a wealth of feedback and encouragement for the research team.

Consultation prior to research funding application

When the research planning was in its early days the research team met with iwi organizations, service providers, government ministries, and funder groups in Hawke’s Bay and Wellington, including DHB representatives and Māori providers delivering health and social services to Māori women under 20 and their infants. The purpose of these visits was to inform these key organizations about the project, and to seek advice about service provision in the respective regions, health and social issues of concern, and the recruitment of Māori women for the study. These visits also established new, and strengthened existing, relationships. Our visiting collaborators, including Professor Stacie Geller from the University of Illinois, were also involved.

The consultation meetings began with cultural protocols of welcome and introduction. Our kaumātua spoke on our behalf during these welcomes, and participated in the meeting discussions. Presentations were given by the research team about the proposed project. As the qualitative study was complementary to an existing retrospective 10-year cohort study of Māori and non-Māori pregnant women and their babies, information on the cohort study was also presented. Discussion occurred during and after the presentations. The consultation meetings went well with people feeding back on and expressing their support for the proposed project happening in their region.

Consultation about the research also occurred between institutions; namely, the University of Otago and Te Rūnanga o Ngāi Tahu (tribal authority). This institutional arrangement ensures that research proposals by staff at the University of Otago are formally approved by the mana whenua—the tribal group that has authority over the lands occupied by the University of Otago in Dunedin. This formality extends to all the University of Otago campuses, including Wellington. From these initial consultations the grant application was developed and submitted, and was successful.

Consultation during the first 6 months of the research

Time was allowed in the first 6 months of the project timeframe for the researchers to return to each community to reconnect with people and meet new stakeholders to discuss the research project with them. Once again our kaumātua accompanied us and cultural protocols were observed during these consultations. We began these second consultations with a
timeline of what had occurred up to that time, including an overview of the funding proposal and where input was being sought. It was during this time that we also consulted students and staff at two teen parent units and began our ongoing relationship with them.

We had retained some flexibility in the study design, including scope for input into the recruitment of participants and their whānau and what we would be asking them about, so that these consultations could feed into the ongoing development of the study protocol. In the next section we canvas the key points that were raised during this and the initial consultations, along with how we acted upon this feedback.

Those attending the consultation meetings were invited to remain in touch with the research project through, for example, being on our contact list and receiving regular updates; being a local advisor; taking part in a key stakeholder interview; helping with recruitment; or commenting on research protocols, interview schedules, analysis, or reporting.

Important conversations took place with Māori research colleagues already conducting, or planning, research with young Māori mothers in Hawke’s Bay. These conversations helped ensure that we would not be competing with other projects for research participants.

**Key points raised during consultation**

Participants raised with us possible differences in circumstances and outcomes between young, pregnant Māori aged 11–15 years, and those aged 16–19 years. In addition, while those under 18 years of age were often cared for by their whānau, the risks for those over 18 of being left to their own devices were also of concern. The response to this feedback was to continue with the research focus on young women under 20 years of age, while recognizing these potential age group differences. We also included in our request for ethical approval for the research the possibility that we might recruit very young women. Other potential differences highlighted by the consultation participants that have been kept in mind include whether the young women are hau kāinga or mātā waka (from local tribes or from tribes residing in other parts of the country), and whether they have been raised by their birth parent(s), been adopted or were whāngai (fostered, usually by relatives).

Participants highlighted the importance of service access, quality and effectiveness, including workforce competency and capabilities. As a participant shared:

Why aren’t girls accessing services? That’s the big question. Is it her upbringing and what that’s taught her about getting help? Or is it she doesn’t want people prying into her business, seeing the way she’s living, judging her? Or is it because services are too pushy, or don’t care, or don’t even know she exists? Do they just make it too hard for girls to come in and seek help? It’s probably a mix of all of these.

There was a lot of feedback about the importance of a 3–5 day stay in hospital (which rarely happens nowadays) for new mothers to receive attention, support and education, including learning to breastfeed. Participants were also interested in examining how linked up different services were to provide a wrap-around service for young women and their babies. This feedback has informed the development of interview schedules for the young women and provider organizations, as well as a lens for examining government policies.

A number of issues were suggested that the young women should be questioned about, including childhood and adolescent experiences, mental health, family violence, behavioural issues, support mechanisms, food security, housing, heating, and education experiences. As a participant shared:

We go into some homes in the winter with four layers of clothes on plus hats and gloves
and don’t take anything off, it’s so cold. We won’t strip baby down for the check-up—it’s just too cold.

Participants were also interested in exploring the intergenerational transfer of knowledge within whānau (e.g., about pregnancy and parenting). These issues have been incorporated into the interview schedules developed for the young women and their support people.

As researchers we were challenged to consider what the young women would be getting from this study. Our response was to budget in our funding application for a monetary koha (gift) for the young women as a thank you for the time they take to be involved in the study. Cell phones and cell phone credits are also provided to many participants to enable the researcher to schedule interviews. We are also bearing in mind other suggestions for a koha; for example, a resource for young pregnant Māori women developed from the research findings.

The aims and objectives of the research project were established from the consultations (see Box 1). Our next responsibility was to ensure avenues for ongoing consultation and advice.

**Ongoing community dialogue**

As potential recruitment sites, it is necessary that there is an appropriate level of ongoing dialogue to assure service providers that their clients/whānau are being appropriately looked after while they are participating in our research. This dialogue takes place both formally and informally. Research team members often present to clinical teams in the primary care setting (Māori health providers, and other health care providers), and community providers (WellChild/Tamariki Ora providers), who work with young people and pregnant Māori women under 20. In addition, formal relationships have been established with local DHB policy and planning teams, as well as Māori relationship boards, and advisory groups within the DHB who have a strategic role in planning for health services in their regions. There are few barriers to arranging and organizing hui with these groups because the health and well-being of young mothers and fathers is a priority health issue. This research helps inform them of some of the challenges as well as positive experiences among young whānau in their region.

**Advisory groups**

From the very early stages the research has been developed under the supervision of Warahi Campbell, the project kaumātua. He has assisted with tikanga (cultural protocol) support throughout the early and ongoing consultation processes, the implementation of the study, and has continued to be a vital member of the research team in terms of cultural guidance, advice and support.

**Kahui Kaumātua**

Under the direction and supervision of our kaumātua, a kāhui kaumātua (council of elders) has been established. The kāhui kaumātua is made up of five kaumātua recognized as being tohunga (experts) in Māori customary and contemporary practices and cultural behaviours, considerations and obligations related to pregnancy and birthing, care of babies, parenting, and provision of support for young mothers and whānau. The kāhui kaumātua assists with tikanga Māori to enable the project team to appropriately navigate and operate within Māori contexts.

**Rōpū mama**

A rōpū mama (group of young mothers) was established to ensure that aspects relevant to the pregnancy journey of Māori mothers under 20 are appropriately considered and included in the study. The rōpū mama members share
their views and experiences of pregnancy and being a mother of a new baby; they also advise on specific aspects of the study (e.g., development of interview questions, recruitment, engagement, and any other topics important to them). Providing this forum for the young mothers also gives the study credibility with the young women who become participants of the study. Building on the relationships the research team had already established with Māori health providers and community networks, members of the rōpū mama were nominated from their respective communities.

**Advisory group**

A multidisciplinary/community advisory group is also working closely with the research team to provide technical and strategic advice and expertise as and when required during the various stages of this project. The group has representation from research, Māori health, midwifery, sexual and reproductive health, and youth policy perspectives.

**Staying connected with government**

Ongoing dialogue with those who make policy and funding decisions that influence and impact on the lives of young people has been effective for keeping the research team updated on government activities, as well as dialogue about developments in the study. Staying connected with agencies has included discussions with Government ministers and officials from agencies such as the Ministry of Youth Affairs, the Ministry of Health, the Office of the Children’s Commissioner, and Te Puni Kōkiri. We have provided updates about our study progress, flagged early areas of interest, and in some instances responded to calls for information.

**BOX 1  Research aims and objectives**

The aims of this project are:

1. To understand the circumstances and range of needs of pregnant Māori women under 20 years old and their infants during their journey through the health system.
2. To examine both the barriers to, and facilitators of, appropriate health care and wellness for pregnant Māori women under 20 and their infants.
3. To use this evidence, in combination with the results from a related cohort study, to design an intervention(s) based on whānau ora (Māori family wellness) to improve maternal and infant health outcomes.

The objectives of this project are:

1. To undertake **case studies** in two geographic and socially contrasting regions to (a) examine the circumstances of pregnant Māori women under 20 and their infants; and (b) identify the health and social services available to pregnant Māori women under 20 and their infants.
2. To develop a **contextual analysis** of access to appropriate care for pregnant Māori women under 20 and their infants by undertaking a review of legislative, regulatory, funding and social policy information.
3. To design an **intervention(s)** based on whānau ora to improve access to appropriate care for pregnant Māori women under 20 and their infants.
These interactions are an important avenue for our research team to stay up-to-date with national developments in child, youth and whānau health and wellbeing, and to seek opportunities to feed into the policy development process.

**Discussion and conclusion**

Māori are a young population and maternal and child ill-health affects a significant proportion of our population. The differences in infant mortality, respiratory hospitalizations and immunization rates between Māori and non-Māori are part of a larger picture of health inequalities in Aotearoa New Zealand and suggest that there is differential access to health services and health system factors contributing to inequalities (Robson & Harris, 2007). Māori as tangata whenua (people of the land) have rights as reflected in the Treaty of Waitangi, which mean that actions should be taken for Māori to have at least the same standard of health, and healthcare, as non-Māori (Bramley, Riddell, et al., 2004). These actions, in turn, should be informed by evidence gathered with, for and by Māori.

Consultation with Māori communities and stakeholders is an essential prerequisite to research being conducted in any region in Aotearoa New Zealand, and this project was no different. The Māori researchers visited and sat with stakeholders from the two regions targeted as research sites, with this targeting being based on pre-existing relationships the research team had with those regions. These relationships meant we could, in some sense, get straight down to business. In another sense this “straight down to business” was set within the context of cultural protocols.

The process described in the present paper is not a prescription for consultation with Māori about health research. Rather, it is a methodology that sets out the importance of working with and for people, highlighting issues/disparities to see if they resonate, and working out ways in which research might be conducted within local contexts. This is about consultation as a mechanism to establish permissions (necessary, but not sufficient), and to begin the development of “mutual thinking”—whakawhitihiti korero—between the researchers and communities to support the research endeavour.

The consultation was not a one-off moment that had a definite beginning and an end after a time- and project-limited journey. Rather, the consultation occurred within the context of existing and newly established relationships, with the post-project relationship continuing indefinitely. These relationships are about the ability of the researchers and the community to call upon one another. This might mean, for example, convening a consultation opportunity/moment, speaking at one another’s special occasions, or catching-up over morning coffee. In this way, consultation occurs within a web of kinship relationships and mutual obligations that is hard to replicate in a recipe-directed way, but reasonably easy to tell the story in terms of the values and principles that it embodies.

Smith and Cram have written about seven community-up research practices that originate from a Kaupapa Māori Research paradigm. These practices are: Aroha ki te tangata—a love for the people; He kanohi kitea—being a face that is seen; Titiro, whakarongo ... kōrero—looking and listening well before speaking; Manaaki ki te tangata—sharing, hosting, being generous; Kia tūpato—being careful; Kaua e takahia te mana o te tangata—not trampling on the dignity of people; Kia māhaki—being humble (Cram, 2001, 2009; Smith, 1999, 2006). These ethical principles guide culturally appropriate research and evaluation practices with Māori and, more generally, with communities. More recently these practices have provided an avenue for encouraging Māori communities to deliberate on the principles and practices they want to apply to research and evaluation in order for their participation to be culturally safe and a good experience. In this way, the
TABLE 1 “Community-up” approach to defining research conduct

<table>
<thead>
<tr>
<th>Cultural values</th>
<th>Researcher guidelines</th>
<th>“E Hine” consultation practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Smith, 1999)</td>
<td>(Cram, 2001)</td>
<td></td>
</tr>
<tr>
<td>1. Aroha ki te tangata</td>
<td>A respect for people—allow people to define their own space and meet on their own terms</td>
<td>• Meeting with mana whenua (local tribal authority)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Being accompanied by the project kaumātua (elder)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Following cultural protocols at meetings</td>
</tr>
<tr>
<td>2. He kanohi kitea</td>
<td>It is important to meet people face to face, and to also be a face that is known to and seen within a community</td>
<td>• Visiting with communities and stakeholders in their own place</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acknowledging and building upon established relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Committing to new relationships that will continue beyond the project</td>
</tr>
<tr>
<td>3. Titiro, whakarongo ... kōrero</td>
<td>Looking and listening (and then maybe speaking)—develop understanding in order to find a place from which to speak</td>
<td>• Being responsive to stakeholder feedback in research design decisions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inviting local community elders and young mothers to have advisory roles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seeking advisory group input into interview schedules, data analysis and interpretation</td>
</tr>
<tr>
<td>4. Manaaki ki te tangata</td>
<td>Sharing, hosting, being generous</td>
<td>• Facilitating opportunities for advisory group members to visit in Wellington, beyond advisory group meeting place</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Creating opportunities for advisory group members to attend international forums</td>
</tr>
<tr>
<td>5. Kia tūpato</td>
<td>Be cautious—be politically astute, culturally safe, and reflective about insider/outsider status</td>
<td>• Gaining appropriate permissions for the research</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Establishing research advisory groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Managing project expectations</td>
</tr>
<tr>
<td>6. Kaua e takahia te mana o te tangata</td>
<td>Do not trample on the mana or dignity of a person</td>
<td>• Liaising with other Māori researchers undertaking research with Māori mothers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Following kaumātua advice to ensure appropriate protocol in meetings</td>
</tr>
<tr>
<td>7. Kia māhaki</td>
<td>Be humble—do not flaunt your knowledge; find ways of sharing it</td>
<td>• Ongoing engagement with Māori health advisory groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acceptance of invitations to talk to other stakeholder groups about the research</td>
</tr>
</tbody>
</table>

Source: Adapted from Smith (2006, p. 2)

community-up research practices have become an example of the sorts of things Māori communities might think about rather than strict guidance that must be adhered to in order for the research or evaluation to be considered Kaupapa Māori. The current project sought to embody these principles through a commitment to stakeholder engagement and ongoing consultation, built upon a foundation of pre-existing as well as newly formed respectful and accountable relationships (see Table 1).

It is no longer appropriate to just count or
describe disparities. We must develop effective programmes that can help to improve health outcomes. The emergent findings from this study and the related quantitative cohort study will inform policy and provide essential information for the design of a protocol for an intervention based on whānau ora, just as in the present study consultative discussions will be a key component of the development of an intervention. On the basis of permissions being sought and given we will proceed to seek funding for this next stage in our research commitment to reducing the health disparities experienced by young Māori women and their babies.

**Glossary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>aroha ki te tangata</td>
<td>a respect for people</td>
</tr>
<tr>
<td>hapū</td>
<td>sub-tribe</td>
</tr>
<tr>
<td>hau kāinga</td>
<td>local people</td>
</tr>
<tr>
<td>hauora</td>
<td>health</td>
</tr>
<tr>
<td>he kanohi kitea iwi</td>
<td>a face that is seen tribe</td>
</tr>
<tr>
<td>kāhui kaumātua</td>
<td>council of elders</td>
</tr>
<tr>
<td>kaua e takahia te mana o te tangata</td>
<td>do not trample on the dignity of people</td>
</tr>
<tr>
<td>kaumātua</td>
<td>elder</td>
</tr>
<tr>
<td>kaupapa</td>
<td>a topic, agenda</td>
</tr>
<tr>
<td>Kaupapa Māori</td>
<td>a framework and way of working built on Māori world view</td>
</tr>
<tr>
<td>kia māhaki</td>
<td>be humble</td>
</tr>
<tr>
<td>kia tūpato</td>
<td>be careful</td>
</tr>
<tr>
<td>koha</td>
<td>gift</td>
</tr>
<tr>
<td>kōrero</td>
<td>to speak, talk</td>
</tr>
<tr>
<td>manaaki ki te tangata</td>
<td>being generous, looking after the person</td>
</tr>
<tr>
<td>mana motuhake</td>
<td>autonomy</td>
</tr>
<tr>
<td>mana whenua</td>
<td>those with authority over the land</td>
</tr>
<tr>
<td>mātā waka</td>
<td>from a tribe outside the local tribal area</td>
</tr>
<tr>
<td>Ngāti Kahungunu</td>
<td>tribal group of Hawke’s Bay</td>
</tr>
<tr>
<td>Ngāti Toa</td>
<td>tribal group of Wellington</td>
</tr>
<tr>
<td>Pākehā</td>
<td>non-Māori</td>
</tr>
<tr>
<td>rōpū mama</td>
<td>group of young mothers</td>
</tr>
<tr>
<td>Tamariki Ora</td>
<td>WellChild programme</td>
</tr>
<tr>
<td>tangata whenua taonga</td>
<td>people of the land</td>
</tr>
<tr>
<td>Te Puni Kōkiri</td>
<td>treasure</td>
</tr>
<tr>
<td>Te Rōpū Rangahau Hauora a Eru Pōmare</td>
<td>Ministry of Māori Development</td>
</tr>
<tr>
<td>Te Rūnanga o Ngāi Tahu</td>
<td>tribal authority of Ngāi Tahu</td>
</tr>
<tr>
<td>tikanga</td>
<td>true, correct</td>
</tr>
<tr>
<td>tino</td>
<td>cultural protocol</td>
</tr>
<tr>
<td>rangatiratanga</td>
<td>self-determination</td>
</tr>
<tr>
<td>tītiro</td>
<td>look</td>
</tr>
<tr>
<td>tohunga</td>
<td>Māori expert</td>
</tr>
<tr>
<td>whakapapa</td>
<td>genealogy</td>
</tr>
<tr>
<td>whakarongo</td>
<td>listen</td>
</tr>
<tr>
<td>whakawhitihiti kōrero</td>
<td>discussion, sharing of ideas</td>
</tr>
<tr>
<td>whānau</td>
<td>family</td>
</tr>
<tr>
<td>whānau ora</td>
<td>Māori family wellness</td>
</tr>
<tr>
<td>whanaungatanga</td>
<td>relationships/kinship</td>
</tr>
<tr>
<td>whāngai</td>
<td>fostered</td>
</tr>
</tbody>
</table>

**Acknowledgements**

Funding was provided by the Health Research Council; thanks to all those consulted. Thanks to Pania Ellison for her support during the development of the research proposal.
References


In S. Hood, R. K. Hopson, & H. T. Frierson (Eds.), *The role of culture and cultural context: A mandate for inclusion, the discovery of truth, and understanding in evaluative theory and practice* (pp. 21–39). Greenwich, CT: Information Age Publishing.


