Mā mahi, ka ora: by work, we prosper—traditional healers and workforce development

Annabel Ahuriri-Driscoll, Amohia Boulton, Albie Stewart, Gill Potaka-Osborne, Maui Hudson

ABSTRACT

AIM: *Rongoā Māori* practitioners make a valuable contribution towards Māori health outcomes, albeit with limited resourcing or formal training. This paper reports on a survey of healers/healing practices—specifically healers' aspirations for professional development and training—and considers the implications for healing practice and future training undertakings.

METHODS: Healers in seven districts around the country were surveyed about rongoā practice and service delivery during 2013. Consenting healers completed surveys either in person, via phone, or returned them via post, according to their preference and convenience. Resulting data were analysed and reported according to frequency of responses.

RESULTS: Thirty-eight healers/*rongoā* clinics completed the survey—a 79% response rate. Respondents were primarily Māori (88%), female (69%), aged 50 years or older (60%), and worked as volunteers. Informal training modes focused on *te reo*, *mātauranga* and *tikanga* were the most common means of skill/knowledge acquisition, and preferred modes for further training.

CONCLUSIONS: The survey highlights the pressing need for expansion of the *rongoā Māori* workforce and training/service funding, to sustain *rongoā* practice. The findings add to what little is known about the training pathways and aspirations of practising healers, identified targets of the Māori Health Workforce Development Plan 2006.

NOTE: REFER TO GLOSSARY AT THE END OF THIS ARTICLE FOR MĀORI TERMS

Māori participation in the health and disability workforce is a key strategy for Māori health development.[1-7] The employment of Māori within health services is a key aspect of improved responsiveness; by recognising the significance of culture to health and adopting appropriate language, custom and outcome measures, Māori health workers are more likely to "actively engage" Māori consumers.[8] Typically, Māori health workforce development is focused on Māori representation within allopathic medicine/allied health disciplines. Māori currently comprise 5% of the total regulated health workforce, despite making up approximately 16% of the total population.[4]

However, Māori health workforce development applies equally to 'culturally constituted' roles or functions, which also make a valuable contribution towards Māori health outcomes (eg, the 'cultural' intermediary role of Māori community health workers[9-11]). The *rongoā Māori* practitioner (*tohunga rongoā*, *puna ora*) is one such role. *Rongoā Māori* is a holistic system of healing derived from Māori philosophy and customs, comprised of several distinct healing modalities.[12-15] Its application varies, according to healer attributes, skills and connection to the surrounding environment.[16] Precise numbers of healers are not known,[14,17] although in 2007 there were 48 *rongoā* practices nationwide affiliated

ISSN 1175-8716
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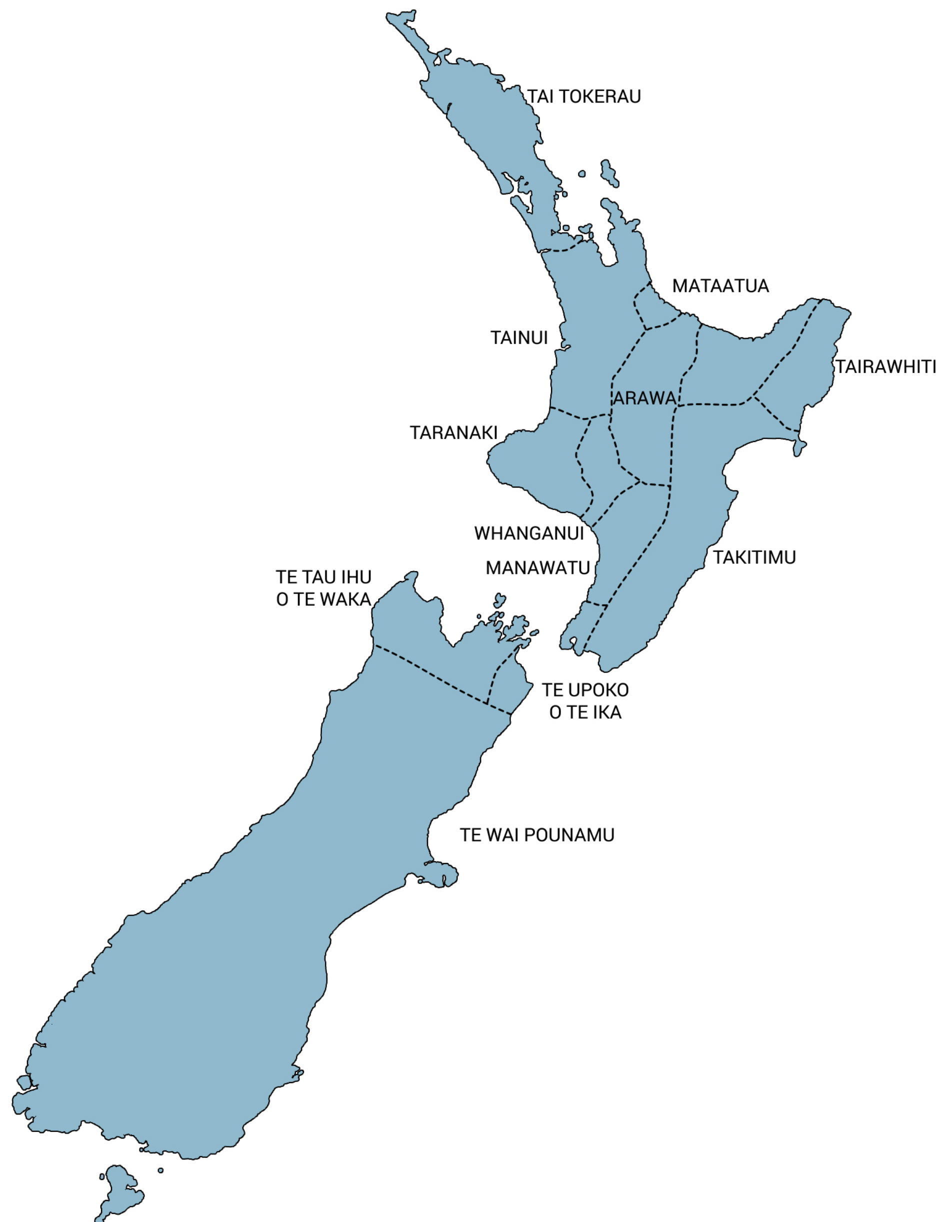
Figure 1: Map of approximate tribal boundaries correspondent with TKR *rohe* boundaries



with the healer-led network Ngā Ringa Whakahaere o te Iwi Māori (NRW).[18] In 2011, these healers merged with another healing collective (Te Paepae Matua) to form Te Kāhui Rongoā Trust (TKR), a new national rongoā governance body comprised of ten rongoā networks around the country (see Figure 1). TKR members were surveyed regarding their modes of practice and funding/contracting arrangements—both 'formal' and 'informal'—for a current Health Research Council-funded project 'Supporting Traditional Rongoā Practice in Contemporary Health Care Settings'. The aim of this paper is to report on the survey findings related to healers' aspirations for professional development and training, which emerged as a key focus.

Method

A survey to gather data on current rongoā practice and service delivery was designed, drawing on team members' knowledge, a literature review and key informant interviews.

Both open-ended and multiple answer questions were utilised to explore practitioner demographics, organisational/practice structure, services/healing modalities provided, current contracts/funding, trainin/expertise and collaborative relationships. The survey form was finalised in June 2013 and piloted in the Tairāwhiti rohe rongoā network. One of the team members, who also happened to be the Chair of the TKR, was able to approach

Table 1: Numbers of individuals working within respondent rongoā practices

Number of staff	Number of practices	Total staff members
1	16	16
2	6	12
3	3	9
4	2	8
5	2	10
6	0	0
7	2	14
8	1	8
9	0	0
10	4	40
11	1	11
45	1	45
Total	**38**	**173**

the various rongoā providers individually and seek their consent for involvement. He then assisted healers to complete the survey, face-to-face. Survey data were entered into spreadsheets, 'cleaned' and compiled into frequency tables. The results were then reported back to the Tairāwhiti rohe members. With survey participants' permission, these analyses were shared with healers from six other rohe (Kahungunu, Waiariki, Whanganui, Taranaki, Te Ūpoko o te Ika and Kāi Tahu), where access to rongoā meetings was granted.

The pilot affirmed the survey questions and format. Given the lack of change between the pilot and full survey administration, the pilot results are included in the final analysis. It was not possible to replicate the pilot approach in the remaining *rohe* however. The recruitment strategy employed varied based on geographical proximity of the *rohe* relative to research team members, familiarity with *rohe* representatives, and *rohe tikanga*. In Taranaki, surveys were completed at several *hui* attended by research team members, over a course of some months. In other regions, individual TKR *rohe* representatives with whom the research team had positive personal relationships, surveyed *rongoā* practitioners on the team's behalf.

Although research team members working alongside healers in person to complete the survey proved the most efficacious way of achieving survey completion, this was not always possible. Subsequently, some surveys were undertaken by phone, or self-administered and returned via post, depending on convenience and healers' preferences.[19] In keeping with the scoping focus, all self-identified practising healers affiliated with regional *rongoā* network/s were invited to participate. These included those serving *whānau*/community on a donation basis, contracted providers, healers working individually and with others. Collectives were asked to identify one person (preferably of a senior/management position) to complete the survey on behalf of their colleagues, conferring with other staff where necessary to complete relevant sections of the form.

Results

By January 2014, a total of 38 surveys across the seven local networks had been received. Non-comparable denominator data complicates the calculation of a response rate. For election purposes, TKR's membership includes non-practising *rongoā* supporters. Based on sector advice, the NRW affiliates list is the most accurate account of active practices/practitioners. Using this as the healing population denominator, completed surveys (38/48) represent a 79% response rate.

Demographics

Thirty-eight *rongoā* practices responded to the survey, encompassing 173 indi-

Table 2: Survey respondents by gender, age group and role/position

Female	Age	*Tohunga*/ principal healer	Support role	No answer	Total
	15–19	0	4	0	4
	20–29	1	8	0	9
	30–39	5	17	0	22
	40–49	6	7	0	13
	50–59	15	17	0	32
	60–69	8	19	1	28
	70–79	2	1	0	3
	80+ years	2	1	0	3
	No answer	0	2	4	6
Female Total		**39**	**76**	**5**	**120**
Male	**Age**	***Tohunga*/ principal healer**	**Support role**	**No answer**	**Total**
	15–19	0	2	0	2
	20–29	2	2	0	4
	30–39	5	1	0	6
	40–49	5	4	0	9
	50–59	5	8	0	13
	60–69	5	2	0	7
	70–79	4	4	0	8
	80+ years	0	1	0	1
	No answer	0	1	1	2
Male Total		**26**	**25**	**1**	**52**
No answer gender		**0**	**0**	**1**	**1**
Total		**65**	**101**	**7**	**173**

viduals. The numbers of individuals working within each *rongoā* practice ranged between one and 45, with two-thirds of respondent practices consisting of between one and three healers (see Table 1). Although the age range of those involved in respondent practices spanned 15–80+ years, those aged 50–59 years accounted for the largest proportion of respondents (26%), followed by those aged 60–69 years (20%). Over two-thirds (69%) of respondents were female, and the large majority (88%) identified as being of Māori ethnicity. Staff in 34 *rongoā* practices (89%) identified having *whakapapa* affiliations to local *iwi* in their areas of practice. Respondent *rongoā* practices were fairly evenly distributed between rural and urban locations (20 and 19 respectively; one practice working across both).

Over a third (38%) of those working within respondent *rongoā* practices (n=173) described themselves as *tohunga*/principal healers: just under two-thirds of *tohunga*/ principal healers (n=65) were aged 50 years and older and were female (63% and 64% respectively, see Table 2). However, women were also more likely to work in supporting positions, comprising three-quarters of *kaimahi*, *kaiāwhina*, *kaiwhakahaere* and *whānau* assistants. In terms of employment status, fifteen percent of respondents to this question (n=162) identified as full-time workers, 13% as part-time workers, half (53%) as volunteers, and the smallest proportion (six percent) were paid employees—several of the latter noted

Table 3: Survey respondents by gender, age group and employment status

Female	Age	Full-time	Casual/ part-time	Volunteer	Paid employee	Other	No answer	Total
	15–19	0	0	3	0	1	0	4
	20–29	1	1	5	1	1	0	9
	30–39	5	2	10	3	0	2	22
	40–49	1	1	8	1	1	1	13
	50–59	6	6	13	3	4	0	32
	60–69	4	7	13	1	1	2	28
	70–79	0	1	0	0	2	0	3
	80+	0	0	2	0	1	0	3
	No answer	2	0	0	0	0	4	6
Female Total		**19**	**18**	**54**	**9**	**11**	**9**	**120**
Male	**Age**	**Full-time**	**Casual/ part-time**	**Volunteer**	**Paid employee**	**Other**	**No answer**	**Total**
	15–19	0	0	1	0	1	0	2
	20–29	2	0	2	0	0	0	4
	30–39	0	1	5	0	0	0	6
	40–49	1	0	8	0	0	0	9
	50–59	3	0	8	1	1	0	13
	60–69	0	1	5	0	1	0	7
	70–79	0	2	3	0	2	1	8
	80+	0	0	0	0	1	0	1
	No answer	1	0	0	0	0	1	2
Male Total		**7**	**4**	**32**	**1**	**6**	**2**	**52**
No answer gender		**0**	**0**	**0**	**0**	**0**	**1**	**1**
Total		**26**	**22**	**86**	**10**	**17**	**12**	**173**

being paid from forms of work other than *rongoā* (see Table 3). No principal healers were paid employees—the majority (69%) reported being volunteers.

Types of training

Informal, culturally-embedded training was the means of skill/knowledge acquisition most commonly cited by respondents. Participation in *hui*/*wānanga* and mentoring with elders were noted by over half of respondents (n=70, 64% and 59% respectively), and '*ngā atua kaitiaki*' (spiritual guidance provided by guardian ancestors) and *iwi*/*rūnanga*/*marae*-based modes were noted by over a third of respondents (39%). Formal training modes were reported by fewer respondents in comparison, although university/college and private training institutions were noted by over a third of respondents (36% and 41% respectively). Nearly a third of respondents (29%) reported only one mode of training and 37% noted between two and three modes of training. Nearly a quarter of respondents (22%) reported between six and eight different training modes.

Te reo, *mātauranga* and *tikanga*, followed by health/*hauora* were the most common subject areas cited by respondents, 74% and 59% respectively. Education/teaching, environmental management and business management were cited by more than a quarter of respondents. Approximately a third of respondents (n=70, 34%) reported training in one subject area, and a further third (35%) noted between two and three subject areas. Over a quarter of respondents (27%) reported between four and six different subject areas.

Table 4: Modes of training according to designated role/position

	Informal training				Formal training			Other	Total positions/ respondents
	Hui	*Iwi*/ marae-based	Elders	*Ngā atua kaitiaki*	PTE	Secondary school	University/ college		
Tohunga/ principal healer	13 (65%)	7 (35%)	15 (75%)	8 (40%)	8 (40%)	2 (10%)	9 (45%)	4 (20%)	20
Kaimahi/ kaiāwhina	17 (65%)	11 (42%)	13 (50%)	8 (31%)	11 (42%)	4 (15%)	7 (27%)	6 (23%)	26
Whānau assistant	3 (60%)	1 (20%)	3 (60%)	1 (20%)	2 (40%)	1 (20%)	0	5 (100%)	5
Kaiwhaka-haere	4 (67%)	2 (33%)	3 (50%)	3 (50%)	3 (50%)	2 (33%)	4 (67%)	2 (33%)	6
Kaumātua	7 (78%)	4 (44%)	6 (67%)	6 (67%)	3 (33%)	2 (22%)	3 (33%)	5 (56%)	9
Other	1 (25%)	2 (50%)	1 (25%)	1 (25%)	2 (50%)	1 (25%)	2 (50%)	0	4
Total responses	**45 (64%)**	**27 (39%)**	**41 (59%)**	**27 (39%)**	**29 (41%)**	**12 (17%)**	**25 (36%)**	**22 (31%)**	**70**

In general, *tohunga* and *kaumātua* report informal modes of training at higher levels than other roles/positions. Those in *kaiwhakahaere* positions are more likely to have formal training, presumably related to their business, management or administrative roles, however respondents in these positions were also highly likely to have undergone 'cultural' forms of training. *Kaumātua* were least likely to have engaged in formal training, perhaps a reflection of both age and historical educational context.

Further training

A high proportion of those who responded to a question about further training (n=60, 85%) answered in the affirmative. Informal, culturally-embedded training modes were most preferred, noted by between a quarter and over half of respondents. In contrast, formal training via secondary school or private training institutions was preferred by between only two and 12% of respondents. Significantly, nearly a quarter of those who ticked options for further training (n=51, 24%) were interested in undertaking this in a university or college. The highest proportion of those who identified subjects for further training (n=48, 67%) expressed a desire to further their learning of *te reo*, *mātauranga* and *tikanga*. Business/management, environmental management and health/*hauora* were identified by 22%, 30% and 38% of respondents respectively. Environmental management was the one area in which respondents' interest in further training exceeded levels of previous training.

Discussion

Rongoā Māori workforce composition

The demographics of respondent healers correspond broadly with those described in previous studies. Parsons (1995)[14] and Jones (2000)[15] point to healing being practiced more often by older Māori living in rural areas. Consistent with these accounts, our survey sample was predominantly—but not exclusively—Māori, and over half (60%) were aged 50 years or older. Broad generalisations drawn by O'Connor[17] about healers fitting this 'traditional' demographic profile include: a distance from 'mainstream' medicine and health/government authorities; a belief in healing as a 'God-given' gift; and operation on a *koha*/donation basis. On the contrary, our respondents were fairly evenly distributed between rural and urban locations, and as part of TKR, are engaging with the Ministry of Health (MoH), some contracted (12 currently, 16 previously) to provide *rongoā Māori* services.

In this sense, a number of our respondents resemble a second group identified by O'Connor—those who are less averse to accepting money for their healing services, common in urban and rural areas, of a wider range of ages, and who attract more non-Māori clientele.

Previous research has not made specific mention of gender composition, apart from acknowledging that both men and women may be expert *tohunga rongoā*.[7,20] The fact that our sample was primarily female may reflect both the predominance of women in many regulated and non-regulated health workforce occupations,[21,22] higher rates of paid employment among Māori men[23] and higher rates of unpaid work among Māori women more likely to be out of the labour force while child-rearing.[24] Similarly to O'Connor's findings, only a very small proportion of our survey respondents are paid for their healing work. The majority are volunteers who work on a part-time or casual basis, around other family/ community roles and responsibilities and other forms of employment.

The demographic features of the healing community have a number of implications for the sustainability of *rongoā*. The healing workforce is older than the general working population, and indeed the health workforce.[21-25] The aging pattern means there is potential for a large proportion of older workers to leave the workforce taking their knowledge and experience with them.[26] The lower numbers of men involved in healing are not necessarily a problem for sustainability *per se*, but there are a number of gender-specific aspects of *tikanga* and *rongoā* that benefit from male input. Most significantly, financial constraints resulting from the largely unpaid work of healers and limited service funding (approximately $1.9 million per year, across 16 MoH contracts[13]) impact upon the capacity of healers to invest in strengthening and developing their practice.[13] Healers and communities will often utilise their personal resources to do so.

Workforce/professional development and training

In earlier research, healers have distinguished between the deep knowledge and spiritual connection of *tohunga*, and the more practical skills application of *kaiāwhina*.[16] This would suggest differing training and education needs for different roles. However, survey responses show less striking differences than might be expected. *Tohunga*/principal healers and support roles report a very similar range of training modes and subject areas (between one and three training modes and subject areas for nearly three-quarters of both groups). There are two surprising findings however: 1) a higher proportion of *tohunga* reported having attended university/ college/polytechnic/*wānanga*; and 2) a higher proportion of those in support roles reported training in *te reo*, *mātauranga* and *tikanga Māori*. Furthermore, although similarly large proportions of *tohunga* and supporting staff indicate interest in further training (89% and 86% respectively), *tohunga*/principal healers reported higher levels of interest in all training modes (informal, culturally-based and within formal institutions) and subject areas. These findings challenge two common assumptions: that *tohunga rongoā*, having reached the pinnacle of healing knowledge, will be less interested in further learning; and also that healing associates/support staff might be less proficient culturally. Alternatively, it may be that these healing roles and distinctions are changing over time, impacted by changes in wider Māori society, or that our conflation of the terms *tohunga* and principal healer has biased responses. Another possibility is that the emergence of *Whare Wānanga*—in which formal training programmes based in a Māori worldview are delivered predominantly by Māori— has increased the appeal of formal tertiary education. What is clear, given the diversity of respondents' training backgrounds and professed interests in further development, is that there is no single pathway that necessarily reflects or will meet all *rongoā* practitioners' needs.

Having said that, apprentice-style learning with other healers prevailed over formal education, as a mode of prior training and a priority for further training. This pattern is consistent with decentralised 'traditional' modes of transmission, in which a capacity for healing identified in young people was nurtured by elders, and the requisite knowledge passed on orally.[16,27] Accord-

ingly, knowledge of *te reo*, *mātauranga* and *tikanga* was deemed the highest priority for further training, emphasising the foundation of *rongoā Māori* in a Māori worldview, and **deep** cultural knowledge. Considering that over half of respondents reported health expertise, there was less interest in this area as a focus for future study than might have been expected. Significant interest in environmental management and business/management perhaps reflects recognition by healers and practices of the business acumen required for *rongoā Māori* service development and delivery, and the importance of the natural environment in terms of sustaining the practice.

How best to support healers' training aspirations has been the focus of discussion and a number of initiatives in recent years.[6,16,28] Healers have advocated for a dual system, drawing on *tikanga*/cultural guidance and support from healers, *iwi*/*hapū*/*whānau* structures, supplemented by institution-based curricula and certification.[15,16] Programmes such as these acknowledge healers' qualification within their own cultural and professional traditions, provide the requisite Māori community mandate to practise,[29] and also align with non-Māori expectations.[15] A number of *rongoā* training partnerships have been established between *iwi* and educational institutions and are attempting to balance theoretical learning with practical experience.

Despite the widespread interest in further learning, established and trainee *rongoā* practitioners are likely to differ in terms of their educational needs. For example, in a recent review of the non-regulated Māori health (*kaiāwhina*) workforce, *kaumātua rongoā* practitioners reported a preference for short workshops complementing their skills and standards to enhance service delivery, rather than structured career development.[30] On the other hand, encouraging young people to move into health workforce development programmes requires that there is financial assistance to complete further education,[25,26] and clear career pathways/training infrastructure.[30] However, healers cite subsistence level resourcing as a key feature of *rongoā* practice; this is an issue for the non-regulated health workforce in general.[22] Indeed, the non-regulated status of the healing workforce has been identified by the MoH as a key reason for curtailing *rongoā* service contracting.[13]

Limitations

As an indigenous healing tradition, *rongoā Māori* is not a practice that lends itself to investigation by quantitative means. Thus, the present survey has several limitations. Firstly, healers opted to participate in the survey rather than being randomly selected; the sample is therefore subject to response bias. Furthermore, incomplete coverage in terms of participating healing networks and small numbers of responses from some areas raise questions about the representativeness of the sample and limit the generalisability of findings. Accuracy of reporting may also have been affected in practices where a respondent answered on behalf of fellow healers/practitioners, and/or that person did not possess knowledge of some of the specific areas surveyed. We have identified that this may have been the case with contracting questions, which require relatively detailed administrative knowledge. Consequently, we have taken care to not overstate the significance of the results. Notwithstanding these limitations, this is the first study of its kind, examining the breadth of *rongoā Māori* practice and service delivery.

Conclusion

Rongoā Māori is a *taonga*, guaranteed Crown protection within *Te Tiriti o Waitangi*/The Treaty of Waitangi.[13] At the heart of *rongoā* are its practitioners, and integral to their retention and recruitment are their training/development needs and aspirations. Corresponding with reports of growth in demand,[13] the survey results highlight the growth desired by healers in terms of knowledge and skills underlying the healing and services they provide. Proficiency in the pillars of Māori knowledge (*te reo*, *tikanga* and *mātauranga Māori*) remains the core of *rongoā Māori* expertise. However, skills to enhance health system-based service delivery are also deemed important by healers. Positively, these dual priorities are reflected in the most recent government strategies for Māori non-regulated health workforce development.[30]

Formalisation of *rongoā* through registration, accreditation, monitoring and evaluation is surmised by the Waitangi Tribunal as the primary means by which additional funding for *rongoā* will be granted within the health sector.[13] Healers are finding their way forward through these issues via TKR, as an authoritative national *rongoā* body. Following a *rohe*-based approach, TKR has produced *tikanga* standards for practice, and in its governance exhibits grounded, professional leadership. It is with the *rongoā* sector that discussions of the implications for healer training currently lie.[30] Survey findings have been provided to each of the rohe to support and inform any such discussions.

GLOSSARY

hapū	kinship group, clan, sub-tribe
hauora	health
hui	meeting, gathering
iwi	extended kinship group, tribe, large group of people descended from a common ancestor
kaiwhakahaere	administrator, director, manager
kaiāwhina	helper, assistant, contributor
kaimahi	worker, employee, staff
kaumātua	elder, elderly man, elderly woman, a person of status within the whānau
koha	gift, present, offering, donation, contribution
Māori	the indigenous people of Aotearoa, New Zealand
mātauranga	knowledge, wisdom, understanding, skill
mahi	work, activity
marae	meeting area of whānau or iwi, focal point of settlement, central area of village and its buildings
ngā atua kaitiaki	guiding spirits
puna ora	literally spring of wellness
rohe	region, area
rongoā	remedy, drug, cure, medication, treatment
rūnanga	tribal council
taonga	treasure, item or attribute of great value
te reo	Māori language
tikanga	customs, traditions
tohunga	skilled person, chosen expert, priest
tohunga rongoā	expert in medicine/healing
wānanga	seminar, forum, conference
wairua	spirit
whakapapa	genealogy
whānau	extended family
Whare Wānanga	a publicly owned tertiary institution that provides education in a Māori cultural context

Competing interests: Nil

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