

TATAURANGA RONGOÄ

Reflections on a survey of rongoä practitioners

Amohia Boulton*

Annabel Ahuriri-Driscoll†

Gill Potaka-Osborne‡

Albie Stewart§

Abstract

In 2013 Whakauae Research for Māori Health and Development conducted a survey of rongoä (traditional Māori healing) practitioners and Whare Oranga (healing clinics) in a number of rohe (regions). In this paper we present the rationale for the survey; outline the intended survey method; report on the methodological adaptations that were required to conduct the survey; and reflect on the impact of these methodological adaptations on the survey implementation overall. Lessons for those conducting similar survey-based research are offered. The paper posits that adapting the data collection process is likely to result in greater uptake of the survey among those rohe who have yet to participate. We conclude that a national picture of the activity being undertaken in the rongoä sector is invaluable to the sustainability of the sector.

Keywords

rongoä Māori, traditional healing, survey, Māori-centred research

* Ngāti Ranganui, Ngāi Te Rangi, Ngāti Pūkenga, Ngāti Mutunga. Associate Director, Whakauae Research for Māori Health and Development, Whanganui, New Zealand. Email: amohia@whakauae.co.nz

† Ngāti Porou, Ngāti Kauwhata, Rangitāne, Ngāti Kahungunu. Lecturer, School of Health Sciences, University of Canterbury, Christchurch, New Zealand.

‡ Ātihaunui-ā-Pāpārangi. Researcher, Whakauae Research for Māori Health and Development, Whanganui, New Zealand.

§ Rongowhakaata, Tūranganui-a-kiwa, Tūhoe. Chair, Te Kāhui Rongoä, Tolaga Bay, New Zealand.

Introduction

Publicly funded rongoä Māori (traditional Māori healing) services have emerged both from a desire on the part of community to improve health services for Māori and in recognition of rongoä Māori as a taonga (treasure) (Durie, Potaka, Ratima, & Ratima, 1993; Jones, 2000; Waitangi Tribunal, 2011). Rongoä services support Māori wellbeing at two levels: providing holistic, culturally consistent assessment and treatment of individual symptoms/conditions, whilst maintaining and revitalising mātauranga (knowledge), tikanga (customs, protocols) and te reo Māori (the Māori language) (Ahuriri-Driscoll, Baker, et al., 2008). High quality rongoä service provision relies on robust practice by practitioners working from a strong cultural base (Ahuriri-Driscoll, Hudson, et al., 2008). Identifying the optimal contractual environments and service delivery elements that support the intrinsic nature of rongoä as a traditional healing practice will, we argue, contribute to its long-term sustainability, to improvements in Māori health gain and to Māori development more broadly.

The Supporting Traditional Rongoä Practice in Contemporary Health Care Settings Project is a three-year study that aims to identify the contractual environments and service delivery elements that will best contribute to the long-term sustainability of rongoä Māori. The Tatauranga Rongoä survey represents one data collection activity undertaken as part of the wider research project. In this paper we briefly outline the rationale for the survey, the methods we had hoped to use to collect data and the modifications to the method that were required, and we reflect on the impact these modifications had to the success, or otherwise, of our collection of survey data.

The Tatauranga Rongoä Survey

The study has a number of objectives in order to meet the overall aim, one of which is to describe and document current arrangements for rongoä practice and service delivery. The survey was conducted to meet this objective.

The survey questionnaire was developed by the research team, who themselves comprise researchers with a track record of working with healers and practitioners in earlier studies (Ahuriri-Driscoll), health services researchers (Boulton, Potaka-Osborne) and a community-based researcher who is also the current Chair of Te Kāhui Rongoä (TKR), the national body for rongoä Māori practitioners (Stewart). Questions were informed by a literature review and a series of key informant interviews.

Information was sought from healers/providers about a range of service delivery aspects, from organisational/practice structure, funding sources, services provided, reporting requirements and client base/service access patterns, to areas for improvement. A combination of open-ended and “tick box”/multiple answer questions were employed allowing participants the opportunity to respond in their own words, and provide feedback not specified in available fields. The survey used a paper-based form and was administered throughout July to December 2013, with analysis occurring from November 2013 onwards.

Originally research team members were to attend TKR national and regional meetings to explain the research, the purpose of the survey, and gain consent to administer the survey in each of the 10 TKR rohe (regions). Additional questionnaires were to be made available for healers who were not in attendance at the regional meetings. Only one survey questionnaire per service was to be completed; therefore, in the case of individual healers, that healer was expected to complete the survey, whereas in larger practices and Whare Oranga (healing clinics), one survey form per practice would be completed. Surveys were to then be posted

back to Whakauae in self-addressed, stamped envelopes. Survey questionnaires would at this point be anonymised for confidentiality and data entry would begin. Each of the 10 TKR rohe was to receive resourcing to assist the research team to recruit survey participants and to compensate the rohe for their time.

Our hope was that in gaining the assistance and buy-in of TKR representatives, recruitment of survey participants would be expedited. However, TKR assistance in recruitment did not occur for two reasons. The first of these was that not all TKR representatives agreed to support the survey. In the early phases of designing the study (i.e. prior to receiving Health Research Council funding) we had been working with Te Paepae Matua mö te Rongoä, a group who was subsequently superseded in 2011 by TKR (Boulton, Hudson, Ahuriri-Driscoll, & Stewart, 2014). That we were no longer working with exactly the same group of governance members by the time the survey was to be implemented, and therefore did not necessarily have the same degree of buy-in to the survey, impacted our ability to recruit through every rohe as planned.

Second, even those representatives who did agree that the survey would provide useful data to the sector found it difficult to justify prioritising survey recruitment above their other TKR work. At the time of the survey TKR was heavily involved in responding to the Ministry of Health's draft Tikanga Standards, a vitally important document that has significant ramifications for the sector, which consequently required much of TKR's attention, capacity and effort. Given the lack of resourcing TKR receive to undertake its mandated role, let alone any further roles requested of them, it became evident that our original plan for conducting the survey was no longer tenable. Consequently our research team altered our recruitment strategy and decided instead to approach those individual TKR representatives at the rohe level, with whom we had already positive personal and working relationships.

Modifications to the method

We used a range of strategies to recruit in the five regions that eventually participated in the survey; our approach being modified depending on location of the rohe, our familiarity with rohe representatives, and the tikanga (customs, protocols) in each of the rohe. In Taranaki, members of the research team were invited to attend a series of regional rongoä hui (meetings) held by the local TKR representatives. At these hui the research team presented information on the study more broadly and on the survey specifically. An opportunity to discuss the survey was made available and hui participants were able to direct questions to the research team. Participants then either completed the survey at that point, or took the survey home to complete.

By comparison, in Tairāwhiti one of the team members, who was also the Chair of the TKR, was able to approach the various rongoä providers individually and seek their support to complete the survey. In the Waiariki region a combination of emails to personal networks, followed up with face-to-face visits and attendance at hui, was employed to garner participants. Because recruitment strategies differed from region to region, conducting the overall survey took place over a number of months. This was especially the case in areas such as Taranaki where research team members met people with an interest in rongoä, who were potential survey participants, at many different hui over a course of some months. Whereas we had originally allowed for six months to conduct the survey, analyse the data and disseminate the results back to the participants, conducting the survey alone took seven months (Table 1).

In total we received 36 completed surveys from seven regions: Waiariki, Tairāwhiti, Kahungunu, Taranaki, and Whanganui, with an additional two surveys from healers based in Te Ūpoko o te Ika and one in Te Waipounamu. It is unknown exactly how many healers there are in Aotearoa currently as the Ministry of Health only keeps data on the number of contracted

TABLE 1 Survey administration

Rohe	Initial contact	Survey completed	Time elapsed
Tairāwhiti	12 July 2013	3 September 2013	2 months
Waiariki	6 August 2013	23 October 2013	3 months
Whanganui	14 August 2013	8 November 2013	4 months
Kahungunu	3 July 2013	24 January 2014	7 months
Taranaki	8 August 2013	14 February 2014	7 months

rongoä clinics. However, it is the view of the research team that in the five primary regions we have achieved a fairly representative sample of those healers who “formally” practise rongoä. For the purposes of our study, we have drawn on O’Connor’s (2008) second of three broad groupings of healers to describe those who formally practise, by which we mean those clinics willing to be involved in the development and contracting of rongoä services and that are visibly and actively engaged in organised rongoä networks.

Reflections on the method

While the idea of collecting information about the rongoä sector, for use by the rongoä sector, was generally supported by practitioners we spoke to, as researchers we still found it difficult to complete the survey within our six-month deadline. In part this was due to the nature of the survey and the perceived usefulness of the results. Team members observed that for rongoä providers, completing the survey was simply regarded as one more demand on their time and energy.

The complexity inherent in the survey document itself may have also contributed to a more drawn out administration of the survey tool. The survey booklet included 29 individual questions, ordered under nine sub-headings. The majority of questions required a tick box answer, although where more detail was required, respondents were asked to provide fuller, written answers. While working alongside people one-on-one to assist them to

complete the survey proved the most efficacious way of getting the survey completed, this method was not always possible for our research team. In rohe where we were able to administer the form in this way, completion of the survey was completed quickly and relatively simply. While face-to-face surveys generally yield the best response rate, issues of cost and the logistics of administering all surveys in this manner can be prohibitive for research teams (Fink, Paine, Gander, Harris, & Purdie, 2011). The response rate for this survey may well have been higher if we had had more time to discuss the survey and the potential benefits of collecting the survey data for the sector.

Having sufficient human resource within our team to complete all the tasks associated with the survey also affected the recruitment to a degree. This was especially so when, as a team, we were recruiting for the survey, analysing data already collected, and disseminating survey results back to rohe. As a team we had undertaken to produce result reports for individual rohe as quickly as possible, both as a way of honouring the relationship we had built with the rohe who participated, and to ensure the good governance of data (Boulton et al., 2014). What we found, given the more protracted recruitment phase, was that we were having to complete a number of unexpected and unplanned “downstream” tasks simultaneously, which placed a degree of pressure on the research team.

A final reflection from administering the survey concerns our stance of being both insiders and outsiders in the survey, and indeed in the study itself (Potaka-Osborne, Stewart, &

Boulton, 2013). One of our team members in particular found that he was able to gain access to providers by virtue of his role as the Chair of TKR. In retrospect, the survey response may be more reflective of the interest in the work of TKR than in the survey or in the research. Once potential participants realised the TKR Chair was also a researcher in the study, the perception of Albie being an “outsider” disappeared. Rather than the relationship being one of “insider–outsider”, or even “researcher–ron-goä healer”, it became one of “ron-goä whānau to rongoä whānau”. A level of trust was immediately offered to Albie and by extension to the research team, which aided in recruitment to the survey.

Lessons for those embarking on similar research

Māori academics have long identified the need for robust processes of information sharing, engagement and consent when embarking on research with Māori (Bishop & Glynn, 1992; Stokes, 1985). Furthermore, in the research context, the importance of working with some-one who is known cannot be overstated (Dyall et al., 2013; Smith, 1999). In our case, under-taking a research project in a sector that is itself marginalised, poorly funded and which struggles to this day to gain legitimacy in the wider health system, we believe has impacted on our ability to engage effectively with the sector.

As a Māori research team we are acutely aware of the vulnerable nature of the rongoä sector, both in terms of the depth of capacity that exists to advance the sector’s strategic goals, and the resources available to support these goals (Boulton et al., 2014). It should therefore be unsurprising that despite a great deal of support shown by many in the sector, we found it a challenge to collect robust data from each and every region of the country.

There are difficulties in calculating an exact response rate for the survey as there is currently

no accurate database of the total number of Whare Oranga clinics or individual rongoä practitioners. Response rate calculations for our survey are based on the current membership of TKR. The problem, however, with calculating the response rate in such a manner is that it produces an inflated denominator because membership of TKR includes practitioners as well as individuals with an interest in rongoä Māori, but who themselves would not be considered healers. Despite the difficulties in calculating a response rate, we estimate that in the regions where data were collected we did manage to canvas the majority of rongoä practitioners. Our success in doing so, modest though it was, we believe was due more to our own personal interactions and the integrity of those than because the sector saw the value of the survey or indeed the research. In other words, a combination of being visible at rohe hui or cluster group meetings, the use of personal networks and having the Chair of TKR as a research team member were more likely to have facilitated our success with the survey, rather than an understanding on the part of participants that the data itself would have any inherent utility.

Conclusion

The information we have collected and disseminated back to regions is already being used by certain rohe in their strategic planning, particularly with regard to issues around workforce, training and succession. Given that the survey results themselves are of use, improving the process by which the data are collected becomes critical if we are to improve coverage of the survey to the point where data are collected from all 10 TKR rohe. Rohe-led surveys, undertaken with the support of rohe trustees and conducted by the rohe members themselves are likely to result in greater uptake of the survey in the remaining five TKR rohe. We would strongly encourage these methodological modifications

to be championed both at the rohe level and by TKR. It is only once we have data from all 10 rohe that a true picture of the health of the rongoä Māori sector emerges. For the future of rongoä Māori, its sustainability and viability as a living healing practice, such data, and the national picture they portray, are invaluable.

Glossary

hui	meetings
mātauranga	knowledge
rohe	regions
rongoä, rongoä Māori	traditional Māori medicine
taonga	treasure
Te Kāhui Rongoä for rongoä Māori practitioners	the national body
te reo Māori	the Māori language
tikanga	Māori customs and protocols
Whare Oranga	healing centres

References

- Ahuriri-Driscoll, A., Baker, V., Hepi, M., Hudson, M., Mika, C., & Tiakiwai, S. J. (2008). *The future of rongoä Māori: Wellbeing and sustainability*. Client Report FW06113, Institute of Environmental Science and Research, Christchurch, New Zealand.
- Ahuriri-Driscoll, A., Hudson, M., Baker, V., Hepi, M., Mika, C., & Tiakiwai, S. J. (2008). Service in practice, practice in service: Negotiating a path to the future. In J. S. Te Rito & S. M. Healy (Eds.), *Proceedings of the Traditional Knowledge Conference 2008. Te tatau pou-namu: The greenstone door—Traditional knowledge and gateways to balanced relationships* (pp. 122–130). Auckland, New Zealand: Ngā Pae o te Māramatanga.
- Bishop, R., Glynn, T. (1992). He kanohi kitea: Conducting and evaluating educational research. *New Zealand Journal of Educational Studies*, 27(2), 125–135.
- Boulton, A., Hudson, M., Ahuriri-Driscoll, A., & Stewart, A. (2014). Enacting kaitiakitanga: Challenges and complexities in the governance and ownership of rongoä research information. *International Indigenous Policy Journal*, 5(2). Retrieved from <http://ir.lib.uwo.ca/iipj/vol5/iss2/1>
- Durie, M. H., Potaka, U. K., Ratima, K. H., & Ratima, M. M. (1993). *Traditional Māori heal-ing: A paper prepared for the National Advisory Committee on Core Health & Disability Support Services*. Palmerston North, New Zealand: Massey University.
- Dyall, L., Kepa, M., Hayman, K., Teh, R., Moyes, S., Broad, J. B., & Kerse, N. (2013). Engagement and recruitment of Māori and non-Māori people of advanced age to LiLACS NZ. *Australian and New Zealand Journal of Public Health*, 37(2), 124–131. doi: 10.1111/1753-6405.12029
- Fink, J. W., Paine, S.-J., Gander, P. H., Harris, R. B., & Purdie, G. (2011). Changing response rates from Māori and non-Māori in national sleep health surveys. *New Zealand Medical Journal*, 124(1328), 52–63.
- Jones, R. (2000). *Rongoä Māori and primary health care* (Unpublished master's thesis). University of Auckland, Auckland, New Zealand.
- O'Connor, T. (2008). *Governing bodies: A Māori healing tradition in a bi-cultural state* (Unpublished doctoral thesis). University of Auckland, Auckland, New Zealand.

- Potaka-Osborne, G., Stewart, A., & Boulton, A. (2013, July). *Wairua rangi rua: Reflections from indigenous researchers*. Paper presented at the He Manawa Whenua Indigenous Research Conference, Hamilton, New Zealand.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous people*. Dunedin, New Zealand: University of Otago Press.
- Stokes, E. (1985). *Maori research and development*. Unpublished discussion paper prepared for the Social Sciences Committee of the National Research Advisory Council.
- Waitangi Tribunal. (2011). *Ko Aotearoa tēnei: A report into claims concerning New Zealand law and policy affecting Māori culture and identity*. WAI 262 (Vol. 2, p. 432). Wellington, New Zealand: Author.

