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**An Indigenous Model of
Health Promotion**

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Indigenous World Views and Health

2004 marks the end of the United Nations Decade of Indigenous Peoples 1995 - 2004. Although many of the aspirations voiced at the commencement have not been realised, the Decade represented a significant advance in the struggle of indigenous peoples for recognition within their own lands and territories and brought global attention to the impacts of colonisation, discrimination, marginalisation and the overt and covert policies that led to ethnocide and sometimes frank genocide. In addition, after nearly eighty years of trying to gain access to the League of Nations and its successor the United Nations, the United Nations Permanent Forum on Indigenous Issues was inaugurated on May 13, 2002.

Although there is no simple definition of indigenous peoples two important characteristics are an ancient relationship with some geographical place and an ethnic distinctiveness from others now living alongside them. There are about 5000 indigenous and tribal groups with a total population of about 200 million, or about four percent of the global population.¹

During the Decade two documents of major importance were formally presented to the United Nations. First the *Draft Declaration on the Rights of Indigenous Peoples* was submitted for ratification.² It had been the subject of discussions between indigenous peoples since 1982 when the Working Group on Indigenous Populations was set up by the Sub-Commission on the Prevention of Discrimination and Protection of Minorities. To the apprehension of some states, who argued that only Government representation

was necessary, the Working Group included indigenous peoples from around the globe. As a result some states refused to participate and others can be expected to withhold ratification when the declaration finally comes before the United Nations General Assembly. Their objections are largely due to the wide definition of indigenous peoples and the emphasis on self-determination. The prospect of a right to secede, and the subsequent break up of a nation-state would constitute the basis for objection from states.³ On the other hand, the *Declaration*, even if ratified, will never be able to assert more than moral influence since it is outside the jurisdiction of international law. Meanwhile, although states may take exception to the *Declaration* and resist its passage through the UN process, it will serve to endorse indigenous aspirations providing a basis for the internationalisation of indigeneity and a platform for shared debate between indigenous peoples if not between states.⁴

The *Draft Declaration* contains 45 articles covering cultural, spiritual, economic, political and constitutional rights. It has major implications for the terms under which indigenous people will live within states and requires states to recognise indigeneity by reference to indigenous heritage, citizenship, the environment and indigenous autonomy.

The emphasis on heritage forms a substantial part of the *Declaration* and the maintenance of an ethnic identity as well as the possession of traditional lands underpins many of the articles. Article 12 for example proposes a right to ‘maintain, protect and develop’ traditions, sites of special significance and ‘intellectual, religious and spiritual property.’ Article 13 adds a right to ‘manifest, practise, develop and teach’ spiritual and religious traditions while article 14 focuses on the right to ‘revitalise, use, develop and transmit to future generations’ histories, language, philosophies and other intellectual

pursuits. In article 24 there is a provision for a right to ‘traditional medicines and health practices as well as protection of ‘vital medicinal plants, animals and minerals.’

Importantly, the heritage rights are about both maintenance and development of culture and resources.

Parts IV and V of the *Declaration* introduce a series of articles that emphasise equitable participation in wider society. Rights to education (in their own language), to the media, to fair labour laws, health, housing and socio-economic improvements are noted. As well a positive role in determining priorities and strategies for social and economic development is envisaged for indigenous peoples.

A special relationship with the natural environment is recognised in Part VI of the Declaration. It is spelled out in article 25 (‘... their distinctive spiritual and material relationship with lands, territories, waters and coastal seas ...’) and in article 27 there is a statement about restitution of lands that have been confiscated or otherwise alienated without consent. Conservation, restoration and protection of the total environment is highlighted in article 28 especially in relationship to the avoidance of pollution and health hazards.

The second document had its origins in 1999 when the World Health Organisation arranged an International Consultation on the Health of Indigenous Peoples in Geneva. Arising from the Consultation a *Declaration on the Health and Survival of Indigenous Peoples* was subsequently prepared and presented to the U. N. Permanent Forum on Indigenous Issues in 2002.⁵ Written in five parts the *Declaration* affirms the basic tenets of the parent *Draft Declaration of the Rights of Indigenous Peoples* but applies them to

health. The links between culture, the wider natural environment, human rights, and health are discussed and a definition of health is proposed.

‘Indigenous Peoples’ concept of health and survival is both a collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimension are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously.’

The *Declaration of Health and Survival* also recommends strategies to improve health including capacity building, research, cultural education for health professionals, increased funding and resources for indigenous health, a reduction in the inequities accompanying globalisation, and constitutional and legislative changes by states. Broad determinants of health are identified: loss of identity, environmental degradation, community development, culturally appropriate care and ‘war, conflicts and vigilantism.’

In effect the two declarations propose that indigenous peoples should have access to the indigenous world with its values and resources, access to the wider society within which they live, access to a healthy environment, and a degree of autonomy over their own lives and properties. They look forward as well as backward and are as much about development as restoration. Whether or not the United Nations General Assembly ratifies the declarations, states will nonetheless need to consider how best to recognise indigeneity and the rights of indigenous peoples in a way that is consistent with the rights of all citizens. There is a potential for conflict between the democratic rights of all citizens and the rights of indigenous people. But the rights proposed in the *Draft*

Declaration are more correctly parallel rights that enhance the concept of citizenship and extend the notion of human rights by enabling full participation in society, including indigenous society.⁶

Two interconnecting threads are woven into the world-view contained in the World Health Organisation definition of indigenous health and survival. One, based on bodily space, unites spiritual, intellectual, emotional and physical domains while the second, time-based, integrates past, present and future. In addition the parent *Draft Declaration on the Rights of Indigenous Peoples*, emphasises the close association between people, the natural environment, and their territories so that the human situation is difficult to consider outside the wider eco-systems that populations inhabit and the political contests that can threaten assimilation.

Indigenous Health Experience

Indigenous peoples, especially those who have become minority populations within their own lands, have suffered comparable patterns of disease. In the eighteenth and nineteenth centuries groups as diverse as Māori in New Zealand, Australian Aborigines, Native Hawaiians, the Saami of Norway, Native Americans and the First Nations of Canada, among others, were nearly decimated by infectious diseases such as measles, typhoid fever, tuberculosis and influenza. For some, including the First Nations, smallpox epidemics produced even greater suffering.⁷

But by the mid-twentieth century, following the near universal experience of urbanisation in the 1950s, other health risks emerged. While communicable diseases continue to affect large indigenous populations around the world, in developed countries

such as Canada and Australia, vulnerability to injury, alcohol and drug misuse, cancer, ischaemic heart disease, kidney disease, obesity, suicide, depression, and diabetes have become the modern indigenous health hazards.⁸

Compared to non-indigenous members of the population life expectancy is significantly lower for indigenous peoples and the incidence of most diseases is higher, sometimes by rates of two or three times (diabetes, mental disorders, some cancers).⁹ However, changes in statistical definitions along with variable enumeration practices make comparisons between groups over time difficult. Biological definitions based on race and estimated percentage of indigenous blood have largely given way to ethnic measures that depend on descent and self identification.¹⁰

Health Determinants

Leaving aside early colonists' views about 'constitutional inferiority,' explanations for current indigenous health status can be broadly grouped into four main causes: genetic predisposition, socio-economic disadvantage, resource alienation, political oppression.¹¹ Possible genetic predispositions have been investigated in diabetes, alcohol disorders and some cancers though are generally regarded as less significant than socio-economic disadvantage, which is often central to contemporary indigenous experience. Poor housing, low educational achievement, unemployment, inadequate incomes, are known to correlate with a range of health problems and facilitate lifestyles that predispose to disease and injury.¹² Alienation from natural resources along with environmental degradation caused by destructive logging, dam building or oil spillage has also been identified as a cause of poor health in several countries while cultural alienation is a

further factor, of particular importance in the delivery of health services.¹³ There is abundant evidence that where clinician and patient are from different cultural backgrounds there is greater likelihood of misdiagnosis and non-compliance.

Several writers have also drawn a link between colonisation and poor health.¹⁴ They argue that loss of sovereignty along with dispossession (of lands, waterways, customary laws) created a climate of material and spiritual oppression with increased susceptibility to disease and injury.

All four positions can be justified and conceptualised as a causal continuum. At one end are ‘short distance’ factors such as the impacts of abnormal molecular and cellular processes, while at the other end are ‘long distance’ factors including governmental policies and the political standing of indigenous peoples. Values, lifestyle, standards of living and culture, so important to clinical understandings, lie midway.

Indigenous Strategies for Health Promotion

While health workers are likely to be more comfortable with the investigation of short distance and mid-distance factors, the health status of indigenous peoples requires a broad approach that covers a wide spectrum of interventions. The *Declaration of Health and Survival* recommends several strategies including capacity building, research (using indigenous methodologies and conventional scientific methods), cultural education for health professionals, increased funding and resources for indigenous health, a reduction in the inequities accompanying globalisation, and constitutional and legislative changes by states. Many indigenous groups have placed priority on the development of an indigenous health workforce that has both professional and cultural competence. They

have also promoted the adoption of indigenous health perspectives, including spirituality, in conventional health services. A return to traditional healing methods has been suggested as a further strategy though generally as part of comprehensive primary health care and in collaboration with health professionals.¹⁵ However, while access to quality health care is important, socio-economic and political gains may have greater potential for improving the health status of indigenous peoples.

Indigenous models for health promotion have relied heavily on indigenous world views and especially the close relationship that people have with the environment, with culture and tradition, and with the social structures and institutional arrangements that characterise indigenous societies. Moreover, because the relationship between indigenous peoples and states is often burdened by past misunderstandings about control and assimilatory policies, indigenous health promoters have also argued for a degree of autonomy from the state.

Māori Models of Health Promotion

Indigenous models of health promotion, including Māori models, generally recognise that health is intimately linked to indigenous world views and indigenous development.¹⁶ One framework for Māori health promotion builds on that philosophy and conceptualises health promotion as a set of activities occupying the space between generic health promotion (i.e. health promotion that has universal application) and Māori development. The framework, *Kia Uruuru Mai a Hauora* includes concepts and principles that are consistent with Māori world views and identifies six key health promotional strategies: reorienting health services towards cultural and health promotional criteria; increasing

Māori participation in society; Māori capacity building; public policies that affirm health and culture; cross-sectoral action for health; and adequate resources.¹⁷

To bring together the several components and to visualise the scope another Māori model for health promotion has also been developed in New Zealand.¹⁸ It uses the imagery of Te Pae Māhutonga, a constellation of stars popularly referred to as the Southern Cross (Crux Australis) that is visible high in the southern skies in Autumn and acts as a marker of the magnetic south pole. Four brilliant stars, Gamma Crucis, Alpha Crucis, Beta Crucis and Delat Crucis in a cross-like formation, make an unmistakable sight, accentuated by two 'Pointers' (Alpha Centauri and Beta Centauri).¹⁹ Te Pae Māhutonga has long been used as a navigational aid and is closely associated with the discovery of Aotearoa.

Because it is an indigenous icon, Te Pae Mahutonga can also be used as a symbolic chart for mapping the dimensions of health promotion, including mental health promotion²⁰ and the promotion of health for indigenous children and young people.²¹

The four central stars can be used to represent four key foundations of health: cultural identity and access to the Māori world (Mauriora), environmental protection (Waiora), well-being and healthy lifestyles (Toiora), and full participation in wider society (Whaiora). The two pointers symbolise two key capacities that are needed to make progress: effective leadership (Ngā Manukura) and autonomy (Mana Whakahaere).

Mauriora: Cultural Identity and Access to the Māori World

The first foundation concerns cultural identity and access to the indigenous world. It is now accepted that good health depends on many factors, but among indigenous peoples

the world over, cultural identity is considered to be a critical prerequisite; deculturation has been associated with poor health whereas acculturation has been linked to good health.²² A health promotional goal must therefore be to promote security of identity. In turn that goal requires ready entry into the indigenous world – a world that encompasses tribal estates, language and culture, family, indigenous networks, and a unique heritage. It is a sad commentary that indigenous peoples often have limited access to their own worlds. The alienation of estates is common enough so that ongoing links with tribal land have very often been severed; but many indigenous languages have also been threatened or even lost altogether, and access to cultural institutions such as marae has often been restricted by geographic dislocation and cultural estrangement.

Although cultures are always in a state of change and a Māori identity in modern times can no longer be considered by the same criteria that were relevant to past generations, access to heritage is nonetheless an important standard for all cultures. A task of health promotion is therefore to facilitate access by indigenous people to the indigenous world including access to language and knowledge, access to culture and cultural institutions, access to sites of heritage, and access to indigenous networks especially family and community.

Waiora: Environmental protection

The second health foundation, Waiora, is linked more specifically to the natural world and includes a spiritual element that connects human wellness with cosmic, terrestrial and water environments. A central element of indigeneity is the close association between people and their accustomed environments - land, waterways, the air, beaches, harbours

and the sea, native flora and fauna. Good health is compromised where there is atmospheric pollution, contaminated water supplies, smog, random mining activities, or commercial developments that exploit the land they cover.

Health promotion must take into account the nature and quality of the interaction between people and the surrounding environment so that there is balance between development and environmental sustainability. It should recognise that the human condition is intimately connected to the wider domains of Rangī and Papatūānuku, the sky and earth parents. In this context health promotion is about harmonising people with their environments by actively promoting those indigenous values that have underpinned the human-environmental relationship over long periods of time, and creating opportunities for people to experience that relationship first hand.

Toiora: Healthy Lifestyles

A third foundation for health concerns personal well-being and healthy lifestyles. Indigenous peoples have their own perspectives on health and well-being. A frequently discussed Māori health perspective is known as Te Whare Tapa Whā, a construct that compares good health to the four sides of a house and prescribes a balance between spirituality (taha wairua), intellect and emotions (taha hinengaro), the human body (taha tinana) and human relationships (taha whānau). A code for sensible living often depended on classifying activities, situations and objects as either risky (tapu) or safe (noa).

Major threats to health come from the lifestyles that emerge from contemporary living and contemporary society. They reflect an imbalance and can be found in patterns of nutritional intake, the use of alcohol and drugs, unsafe roadway practices, tobacco use,

disregard for the safety of others, unprotected sex, sedentary habits, reckless spending, and the use of unsound machinery, including motor vehicles. Protection from injury, self-harm, and illness are major challenges facing health promoters. Too many indigenous peoples, young and old, are trapped in risk-laden lifestyles and do not have recourse to the codes of living that may have protected their grandparents from harm. They have little chance of ever being able to realise their full potential. The loss to indigenous wealth, and to the wealth of nations is correspondingly high.

Toiora depends on personal behaviour. But it would be an oversimplification to suggest that everyone had the same degree of choice regarding the avoidance of lifestyle risks. Risks are especially high where poverty is greatest, where risk-taking behaviour is the norm within a family or community, and among youthful populations. Risks are also increased if risk-taking behaviour is condoned or implicitly encouraged.

Whaiora: Participation in society

A fourth foundation for health, Whaiora, correlates with indigenous participation in wider society and the extent of that participation measured against material circumstances, social equity, cultural affirmation, justice, and effective representation. Well-being is about the goods and services that people can count on, and the voice they have in deciding the way in which those goods and services are made available. In short, full participation is dependent on the terms under which people participate in society and the confidence with which they can access quality personal services, sport and recreation, meaningful employment or governance.

There is abundant evidence that indigenous participation falls considerably short of the standards of a fair society. Disparities between indigenous and non-indigenous populations are well documented and confirm gaps on almost every social indicator. Worse still, in a number of key result areas the gaps are growing.²³ Health promotional goals need to consider ways in which indigenous participation in society can be increased especially in relationship to the economy, education, health services, modern technologies, incomes, and decision-making. Health policies and health legislation are important but health status is affected by many other sectors and health impacts are likely to be found as a result of legislation and policies across a wide range of government portfolios and departments.

Ngā Manukura: Leadership

A common indigenous experience has seen public agencies and health professionals assume positions of leadership on behalf of indigenous peoples. However, not only did that approach foster both dependency and assimilation, but it also undermined indigenous leadership, now generally regarded as an essential component of health promotion. Indigenous leadership should reflect a combination of skills and a range of influences. It is multi-faceted and includes tribal leadership, community leaders, sectoral leaders (such as health professionals or teachers), elected representatives, and leaders from the academy.

Non-indigenous health professionals have important roles to play but should not suppress the leadership that already exists in indigenous communities, especially where indigenous capacity has not been able to keep pace with health demands and need. While

tribal and community leaders may not have technical and professional skills, they do possess an intimate knowledge of their people and have the decided advantage of being able to communicate in a vernacular that makes sense. In any event, health leadership will be more effective if a relational approach is fostered and alliances are established between groups who are able to bring diverse contributions to public health programmes.

Mana Whakahaere: Autonomy

Colonisation very often supplanted indigenous forms of governance and management creating instead dependency and marginalisation. It is clear from the *Draft Declaration of the Rights of Indigenous Peoples*, however, that dependency is not compatible with human dignity or good health. Campaigns by indigenous peoples for greater autonomy have resulted in tension and sometimes open conflict with states. However, although disputes remain about property rights, control of resources, representation, and the manner in which goods and services are made available to indigenous peoples, a number of pathways are able to give expression to the spirit of self governance. Some of these, such as tribal development programmes assume a high level of indigenous control and leadership. Similarly even though they operate within the framework of a state contract, a number of non-tribal community organisations have their own systems of governance and management.

But key to autonomy are the constraints of capability and authority. In many countries, including New Zealand, indigenous workforce development has been afforded some priority though not without creating controversy especially when affirmative action programmes have been introduced or indigenous world-views have been woven into the

curriculum or indigenous values have been applied to clinical interventions and key performance indicators. Indigenous peoples, however, are interested in a workforce that has dual competencies – professional competence and cultural competence.

Autonomy is always relative and on a continuum between total state control at one pole and indigenous sovereignty at the other, most indigenous peoples contend that they are forced to locate themselves too close to the state pole. Devolution of control to indigenous peoples by, for example handing over indigenous hospitals to tribes as occurred with many Indian Health Service facilities in the United States, has been one mechanism for shifting authority away from the centre. Contestable contracting for services as practiced in New Zealand has been another. In that case a distinction has been made between contractual environments where providers must compete for funding alongside other service providers, and contracts where the funder is an indigenous-specific government authority. In the latter instance services are likely to be more comprehensive with more favourable financial arrangements compared to services that operate in a competitive environment.²⁴ In addition the whole-of-government approach is more compatible with indigenous preferences for integrated (rather than sectoral) development.

Implications

Te Pae Māhutonga is one way of bringing together the threads of health promotion. It is not so much a model for best practice as a schema to identify the parameters of practice, and to signpost the strategic directions that might be pursued by states, the health and education sectors, and indigenous peoples themselves. Most important, indigenous health

issues cannot be seriously addressed unless they are part of a wider discussion that includes cultural identity, the natural environment, constitutional arrangements, socio-economic realities, and indigenous leadership.

Inevitably this broad approach raises challenges for the state. A particular issue concerns the way indigeneity is recognised at constitutional levels. While most governments are willing to recognise cultural diversity as a modern reality, not all are comfortable about acknowledging indigenous peoples as populations with unique rights based not solely on cultural distinctiveness but also on a longstanding relationship with the territory, predating colonisation. Even when treaties have been signed to that effect, there has been debate about their enforceability in modern times. Some states are also inclined to view health spending entirely according to individual health need, and they dispute population-based funding as a rational basis, especially when ethnicity or race is the population in question. But while the principle of equality as between individuals can be defended as a democratic principle, it is only one principle that underpins a modern democracy. Equality as between populations must also be factored in to the responsibilities of the state; and in that respect indigenous peoples have well-established claims for recognition as distinctive populations.

A third challenge for states is to consider indigenous health within a broad framework accepting that the determinants of good health are reflected in a range of public policies - environmental policy, policies that strengthen cultural identity, policies that facilitate equitable participation in education, society and the economy, and policies relevant to decision-making and the exercise of authority.

Indigenous leadership, whether emanating from tribal structures, the community, or sectors such as health and education, will be similarly challenged by the comprehensive nature of health promotion. Particularly demanding will be the challenge to straddle the two worlds within which their people live. Most indigenous peoples spend their everyday lives on the border between the indigenous world and a set of norms constructed by a wider society. If indigenous leaders are unfamiliar with either world they will find it difficult to understand the reality of their people. Language, cultural values, cultural protocols and indigenous associations at community, tribal and even national levels will be important vehicles for communicating and assisting individuals and families. But equally, understanding the impacts of lifestyle risks, educational achievement, economic success and technological competence will be necessary for the execution of effective leadership.

For other reasons practitioners of health promotion will also be challenged by indigenous perspectives. Inter-cultural misunderstandings may create barriers for effective care but unless practice is consistent with the broad aspirations of indigenous peoples, then no matter how professional it is delivered, in the end it may hinder rather than facilitate good health. Both cultural safety and cultural competence are based on the observation that health practitioners who do not take culture into account in diagnostic and management protocols fall short of acceptable standards of practice.

Because self-determination is a key indigenous aspiration, the establishment of self-managing indigenous health services is an important aspect of health promotion. In such services the norm will be based as much on indigenous world-views as on health sciences and although being part of the health sector, they will also be part of the

indigenous network.²⁵ Indigenous health programmes have the capacity to deliver services to indigenous peoples because they are linked to economic, social and political aspects of indigenous development. Conversely a health programme that exists in isolation of other components of an indigenous community will miss the inter-sectoral opportunities and networks that impact on people in their everyday lives. Sectoral division runs counter to indigenous views on interconnectedness. The goal, therefore, is not simply to have an indigenous health service but to have a health service that is clearly part of indigenous society.

The Interface

There is of course a vital role for indigenous practitioners of health promotion and health education. Their contribution to indigenous health and more broadly to indigenous development, will stem mainly from being at the interface between two worlds: the indigenous world and the globalised world.²⁶ Living at the interface and inhabiting two spheres could be a source of confusion. But it could also be but a site of potential. Wise leadership requires careful management of the interface so that the benefits of modern technologies and science can be transferred to indigenous clients in ways that strengthen indigenous world-views and contribute to good health.

For too many indigenous people the interface between the indigenous world and society at large has become a giant chasm within which human potential has been drowned. Indigenous health workers have a special role to play in negotiating the interface. By virtue of their backgrounds and their professional training they have access to two bodies of knowledge. They are in a position to bridge the gap between the world

where indigenous values dominate and the world dominated by science, technology and global imperialism.

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- ¹ R. Howitt, (ed.), (1996), *Resources, Nations and Indigenous Peoples*, Oxford University Press, Melbourne, pp. 10-11
- ² Working Group on Indigenous Populations (1993), *Draft Declaration on the Rights of Indigenous Peoples: Report of the Eleventh Session of the United Nations Working Group on Indigenous Populations*, United Nations, Geneva
- ³ F. M. Brookfield, (1999), *Waitangi and Indigenous Rights: Revolution, Law & Legitimation*, Auckland University Press, Auckland, pp. 75-77.
- ⁴ K. S. Coates, (1998), 'International Perspectives on Relations with Indigenous Peoples', in Coates, K. S., McHugh P. G., *Living Relationships Kokiri Ngātahi The Treaty of Waitangi in the New Millennium*, Victoria University Press, Wellington pp. 34-40.
- ⁵ Committee on Indigenous Health (2002), *The Geneva Declaration on the Health and Survival of Indigenous Peoples*, United Nations Permanent Forum on Indigenous Issues, New York.
- ⁶ Mason Durie, (2002), *Universal Provision, Indigeneity and the Treaty of Waitangi*, presented at the Roles and Perspectives in the Law Conference in Honour of Sir Ivor Richardson, Wellington.
- ⁷ James Waldram, D. Ann Herring, T. Kue Young, (1995), *Aboriginal Health in Canada Historical, Cultural, and Epidemiological Perspectives*, University of Toronto Press, Toronto, pp. 55-61.
- ⁸ J. Cunningham, J. R. Condon, (1996), Premature mortality in aboriginal adults in the Northern Territory, 1979-19991, *Medical Journal of Australia*, 165(6): 309-12.
- ⁹ for further discussion see Kunitz, Stephen J. (1994), *Disease and Social Diversity The European Impact on the Health of Non-Europeans*, Oxford University Press, New York
- ¹⁰ Mason Durie, (1998), *Whaiora Māori Health Development*, Oxford University Press, Auckland, pp. 123-26.
- ¹¹ Mason Durie, (2003), 'Providing Health Services to Indigenous Peoples', Editorial, *British Medical Journal*, 7412, 23 August 2003, pp. 408-409
- ¹² National Health Committee, (1998), *The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health*, National Health Committee, Wellington.
- ¹³ E. Duran, B. Duran, (1995), *Native American Post-colonial Psychology*, State University of New York, Albany, pp. 93-156.
- ¹⁴ A. Cohen, (1999), *The Mental Health of Indigenous Peoples: An International Overview*, Nations for Mental Health, Department of Mental Health, World Health Organisation, Geneva, pp. 7-10.
- ¹⁵ Wayne Warry, (1998), *Unfinished Dreams: Community Healing and the Reality of Aboriginal Self-Government*, University of Toronto Press, Toronto, pp. 166-170.
- ¹⁶ Riki Niania, (2000), *Te Tini Roto Te Tini Ora Health Promotion: Purchasing Health Gains for Māori*, Masters thesis, Massey University, Palmerston North.

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- 17 Mihi Ratima, (2001), *Kia Uruuru Mai a Hauora Being Healthy, Being Māori Conceptualising Māori Health Promotion*, PhD thesis, Massey University, Palmerston North, pp. 230-261.
- 18 Mason Durie, (1999), 'Te Pae Mahutonga: a model for Māori health promotion', newsletter, Health Promotion Forum of New Zealand, 49: pp. 2-5.
- 19 Vicki Hyde, (2003), *Night Skies Above New Zealand*, New Holland Publishers, Auckland, pp. 150-153.
- 20 Ministry of Health, (2002), *Building on Strengths A new approach to promoting mental health in New Zealand/Aotearoa*, Wellington, p. 44.
- 21 Mason Durie, (2003), 'Te Pae Mahutonga: Mental Health Promotion for Young Māori', in M. Durie, *Ngā Kāhui Pou Launching Māori Futures*, Huia Publishers, Wellington, pp. 141-156.
- 22 W. W. Isajiw, (1990), 'Ethnic-identity Retention', in R. Breton, W. W. Isajiw, W. E. Kalbach, J. G. Reitz (eds), *Ethnic Identity and Equality*, University of Toronto Press, Toronto, pp. 34-91.
- 23 Te Puni Kokiri, (2000), *Progress Towards Closing Social and Economic Gaps Between Māori and Non-Māori*, Ministry of Māori Development, Wellington.
- 24 Josee Lavoie, (2003), *Indigenous Primary Health Care Services in Australia, Canada and New Zealand: Report on four case studies*, a Report for Raukawa Hauora, London School of Hygiene and Tropical Medicine, London.
- 25 Mason Durie, (2001), *Mauri Ora The Dynamics of Māori Health*, Oxford University Press, Auckland, pp. 226-47.
- 26 Mason Durie, (2003), 'Indigeneity: Challenges for Indigenous Doctors', in M. Durie, *Ngā Kāhui Pou Launching Māori Futures*, Huia Publishers, Wellington, pp. 269-88.