Linking Health, Place and Healthy Communities

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ABSTRACT: This paper poses the question of what comprises a healthy community. In addressing the question, we explore the common ground lying between the subdiscipline of health geography and the philosophies of health promotion. Building on the ideas of Maori academic Mason Durie, we propose a framework for conceptualising healthy communities. We provide some context to the New Zealand origins of our thinking, then illustrate the essentially integrative character of the framework through offering a case study drawn from our research in New Zealand dealing with suburban parenting. We conclude that the challenge to researchers, planners and policy makers is to find ways to translate the holism of such frameworks from policy into practice. Notwithstanding this challenge, we contend that there is merit in seeking to reaggregate, rather than disaggregate, the diverse influences upon healthy communities.
KEYWORDS: Community, Health, New Zealand, Maori.

RESUM: Aquest article posa en qüestió en què consisteix una comunitat saludable. En l'anàlisi d'aquest fenomen s'exploren les bases que tenen en comú la subdisciplina de la geografia de la salut i les filosofies de la promoció de la salut. Treballant sobre les idees de l'acadèmic maori Mason Durie, proposam un marc per a la conceptualització de les comunitats saludables. Oferim un breu repàs del context neozelandès, on s'origina aquesta proposta, per il·lustrar-ne llavors el caràcter essencialment integrador, oferint un cas d'estudi de la nostra recerca a Nova Zelanda sobre la relació de parentesc suburbà. Concloem que el repte per als investigadors, planificadors i polítics és trobar vies per traslladar l'holisme d'aquests entorns de la política a la pràctica. Tanmateix, ens satisfà el mèrit de la recerca per agregar, més que per disgregar, les influències diverses entre les comunitats saludables.
PARAULES CLAU: comunitat, salut, Nova Zelanda, maori.

[1] An extended and alternative version of this paper will appear in 'Living Together' (edited by M Thompson-Fawcett and C Freeman) Oxford University Press (forthcoming 2005).

1. Introduction

What characterises a «healthy community»? This question is central to both the practice of health promotion and the discipline of health geography. Indeed, the link between health and place is central to the pursuit of well-being and to learning how to live in a sustainable manner. While the last decade has seen health geography progress beyond the restrictive concerns of its previous incarnation as medical geography, the recent grappling with links between culture, place and health (Gesler and Kearns, 2002) can be regarded as failing to engage deeply enough with the intersections of local cultures, environments and aspirations.

This paper seeks to explore such intersections with specific reference to the context of our own research in Aotearoa/New Zealand. Here, there is a three-fold imperative to pose the question of what makes for a healthy community. *First*, the physical and social dimensions of daily life in our settlements are becoming increasingly stressed though influences ranging from traffic congestion, noise pollution, loss of green space and rationalisation of service locations. There is a growing sense that development is fast approaching the limits of comfort in terms of liveability. Urban development is increasingly and implicitly justified by an uncritical imperative for 'growth'. It therefore seems timely to step back from examining component 'problems' and attempt to adopt a broader integrative perspective on community life.

Second, health policy discourses have recently shifted to encompass a population-wide perspective, acknowledging a wide range of social and environmental determinants. Examples include growing recognition of links between transport and health and associated campaigns to halt drink driving, promote walking and endorse physical activity more generally. *Third,* there is a growing recognition that distinctive frameworks for conceptualising health developed from an indigenous Maori worldview hold potential to advance thinking beyond biomedical perspectives on health and development.

This triple rationale –the limits to growth, the merging population health perspective, and Maori ideas of health– prompts us to reflect on what healthy communities in Aotearoa New Zealand are or might be. We undertake this examination at a time when the broad questions of national identity and its implications have never been closer to the surface of the national consciousness.

We begin by sketching a cultural context of contemporary New Zealand. We then consider what meanings might be attributed to the two key terms of our title – *healthy* and *communities*. We draw particularly on the theoretical thinking of the leading Maori health scholar, Mason Durie (1999). His *Te Pae Mahutonga* framework is presented and developed to allow a critical reflection on the links between people, place and well-being, the central concerns of contemporary health geography. We then illustrate selective dimensions of healthy communities through a case study drawing on our research: daily life for suburban residents in Beach Haven, a suburb of North Shore City, Auckland. We close with some reflections on the links between healthy communities and sustainable settlements.

2. Linking culture and place in Aotearoa/New Zealand

The current relationship between Maori and Pakeha arises out of Britain's sustained colonization of New Zealand in the 1800s and the active opposition to this process by some Maori (Kearns and Berg, 2002). The

British Crown and (some) Maori chiefs signed the Treaty of Waitangi in 1840, guaranteeing *te tino rangitiratanga*, or Maori sovereignty, and *mana whenua*, or control of land (Orange, 1987). According to Nairn and McCreanor (1991) a 'collective forgetting' of the Treaty soon beset British settlers, allowing for a British Act of Parliament to establish 'responsible' settler government without Maori representation. British desire to acquire Maori land drove them to armed conflict in order to establish their dominance (Belich, 1986). While the British troops were never able to inflict any decisive military defeat, they managed to grind Maori resources down to the point where they were unable to organize effective and sustained resistance to Pakeha colonization. More than 1.6 million acres of tribal lands were confiscated following the New Zealand Wars, ostensibly as punishment for Maori 'rebellion' against the Crown (Walker, 1990). Between 1840 and 1911, the proportion of New Zealand land controlled by Maori dropped from 100 percent to just 11 percent (Pawson, 1992). Maori population decline was equally dramatic, dropping from about 80,000 in 1840 to just 41,993 individuals in 1891. Conversely, the European settler population increased from a few hundred individuals in 1840 to more than 770,000 in 1901 (Pool, 1991).

Some Maori have struggled against the state (and against international capital) for recognition of their rights since the early colonial era. In more recent times, this struggle has been reflected in a resurgence of Maori cultural forms, and increasing calls for self-determination (Walker 1990). The state and Pakeha New Zealanders have responded with a number of concessions such as formation of the Waitangi Tribunal, a standing commission of inquiry created in 1975 to examine Maori Treaty grievances. Maori have won a number of significant claims put to the Waitangi Tribunal and this has led to government recognition of land rights, allocation of greater fishing resources to Maori and the establishment of numerous statutory bodies to deal with Maori concerns (Walker, 1992). These victories have, however, been tempered by the New Right monetarist policies implemented during the period 1884-1999 by both Labour and National governments (Le Heron and Pawson, 1996).

Notwithstanding this history and political struggles, most Maori continue to feel deeply at home in Aotearoa New Zealand. This connectedness is possible because Maori regard themselves as *tangata whenua* (literally, people of the land), a status acquired by living entirely off the land within their tribal territories for generations prior to European contact. In the forgoing name, the word '*whenua'* has particular significance, carrying two meanings: land and placenta. These otherwise disparate meanings are tangibly linked in a tradition (now adopted by some Pakeha) of burying the placenta after a child is born on land where there is some pre-existing significance. Thus, people and land become inextricably linked through the materiality and spirituality of life itself. As Smith (2004) describes it:

> «… the phrase *tangata whenua* has a deeper, more significant meaning of being 'composed of' the elements of that place through generations and centuries of occupation; for the people not only passed 'through' or over the land but the land passed 'through' and made up the substance of the people both physically and metaphysically»

The deep sense of belonging and 'being at home' underscores the development of innovative models of health by commentators such as Maori psychiatrist Mason

Durie (1994) who has advocated nurturing the idea of tangata whenua and linking it to mental health and general well-being.

3. Policy precedents for healthy communities

Before introducing and extending Durie's thinking, we must acknowledge that the idea of exploring the features of a healthy community is partly an outgrowth of the principles of the Healthy Cities. This movement arose from the recognition that many of the influences shaping the health of people lie outside the formal health care system. In other words, there is a frequent disconnection between popular and professional perceptions as to the determinants of health. Those working within health care services understandably are preoccupied by their apparent importance to human health. However, when members of the public are asked what is important for their health, the response often centres on features such as families, friends, neighbours, satisfying jobs, good housing and supportive neighbourhoods (Witten et al, 2001).

This principle of the Healthy Cities movement builds on the fact that the more significant contributions to human health over the past 150 years were made by local government through improvements in such elements of the urban infrastructure as sanitation and water treatment. According to their proponents, healthy cities mean that resources are available to provide a safe and supportive environment for citizens of all ages, an educated and stable work force to support economic development, and caring people that are capable of addressing the complex issues facing cities today.

To this extent, the healthy cities ideas are a counter-discourse to a long-established view dating back to the industrial revolution that cities are bad for one's health. Metaphors such as 'the urban jungle', the 'big smoke' and 'the rat race' bear strong inference that a healthier life is to be found beyond, rather than within, the city limits. The problem with these ways of framing urban life is that they tend to imply a tolerance of unhealthy environments and a broad, and often unattainable, yearning to escape to a simple healthy life in the country.

To displace such views, the healthy cities approach incorporates a broad definition of health, one that emphasizes prevention of community problems and the development of people. A view of health consonant with socio-ecological ideas is seen to encompass all aspects of people's lives including housing, education, religion, employment, nutrition, leisure and recreation, health and medical care, good transportation, a clean and green environment, friendly people, and safe streets and parks that all help to promote a healthy city or town. Although these ideas have been applied within the New Zealand context as well as in other countries, it is our contention that their applicability may well be enhanced with the adoption of a framework that has been borne out of metaphors deeply rooted in this land and people. Before moving to the framework we propose, we need to consider the nature of community.

4. Conceptualising Community

What is community and what are its links to health and place? The experience of community, even in large cities, has conventionally been linked to ideas of locality-based social ties through the ongoing influence of sociologists such as Durkheim and Tonnies. 'Community' in this view invokes ideas of connectedness, shared values, and belonging. Historically, the

concept has been assumed to be linked to kinship, stability and bounded physical location, and the influence of these assumptions can be seen in American and British community studies up until the 1960s. Since then, the emphasis has shifted to attempting to understand change and conflict as dominant motifs underlying the study of community. To understand community (and by extension, sense of place) we need to break away from an intellectual tradition shaped by 19th century sociologists which «associated community with a disappearing world of traditional solidarities and values» (Albrow, 1997, 24). More recently, ideas of non-locational community have been proposed to signal the way that distant social relations can strongly influence local experience, especially within diasporic communities (e.g. Friesen et al, 2003). As Albrow et al. (1997) assert, migration can lead to the erosion of place-bound experiences of belonging both from place of origin and place of arrival. An increasing recognition of cultural differences in the degree to which place matters in belonging therefore adds another layer to the 'problematic' of community in 21st century New Zealand and elsewhere (McCreanor et al, 2004).

Despite a broad set of assumptions about the health-related benefits of social cohesion as a by-product of community, there is a growing body of literature reporting a decline in a sense of community based on neighbourhood and physically proximate ties. We increasingly see reference to notions of virtual community (e.g. internet chat rooms) and communities-of-interest (e.g. 'the gay community'), neither of which necessarily involve any spatial co-location As communities-of-interest as spatially dispersed networks become increasingly the norm and familiarity with those living close at hand declines, we can ask "how 'healthy' are such developments for our cities and settlements, and for living together as citizens more generally?" These questions beg a larger question – that of the nature of health itself.

5. Conceptualising Health

A focus on healthy communities (rather than healthy individuals) implies a shift in mindset from the conventional medical preoccupation with personal health to a concern for population health. This shift has also underlain a movement in subdisciplinary focus and identity from medical to health geography (Gesler and Kearns, 2002). Acting in the interests of the well-being of *all* members of a nation consisting of interlinked place-based communities implies a commitment to maintaining and sustaining the quality of a range of environments including the social/cultural, political, built and 'natural' setting.

Such a view draws on the breadth of vision encapsulated in the Alma Ata declaration where health is seen as «complete social, physical and mental well-being and not just the absence of disease…» as well as more recent socio-ecological formulations that embody holism and a future-orientation in order to anticipate ongoing threats to, or erosion of, health (Gesler and Kearns, 2002). The adoption of the term 'well-being' in the context of the Alma Ata declaration represents an attempt to bypass the medically-captured term 'health' with its implied baggage of disease-orientation to signal a set of broader, positive inspirations around medium to long-term human potential.

The interdependence of the social with mental and physical health is increasingly recognised (refs), implying that health must be conceptualised in terms broader than the biophysical. This linkage is recognised within the Ottawa Charter of Health Promotion which has become an influential

framework for conceptualising and formulating policy around dimensions of empowerment, community action, and capacity building. However, we believe that notwithstanding its powerful role in shifting thinking on the international stage, the Ottawa Charter has limitations within more localised settings where key dimensions of health and wellbeing are bound into our history of colonisation and the power politics of place. Invariably, international statements are insufficiently sensitised to cultural difference to encompass the power dimensions inherent within the specific colonial processes that have shaped our society and history (Wepa, 2004).

A key problem is that although it is increasingly conceptualised in a positive fashion, health continues to be measured in negative terms. This occurs with respect to personal health as well as population health. In its crudest manifestation, for instance, mortality rates are used as indicators of health status. Similarly, rates of high blood pressure or limiting long-standing illness only indirectly speak of how well people or populations feel about themselves or their lived environments.

Extending this view to the theme of healthy communities, it is relatively straightforward to say what the parameters of an unhealthy community would be. For example Marmot and Wilkinson (2001) have produced a pithy summary of the major social determinants of ill-health. They cite social gradients in income, social exclusion, unemployment, lack of transport and access to services, poor nutrition, and addictions as key determinants of health status. These factors could, hypothetically, be developed into a comprehensive set of indicators and applied to communities. However even at this level questions and challenges arise. Clearly such indicators would be applied in the absence of an absolute standard of 'performance' in a population and would therefore be comparative measures. Issues of cultural relativity would arise. There would also be issues around the scale and form of the community referred to and an array of compositional (population-related) and contextual (area-related) factors that ought to be kept in mind. Thus even with an appropriate degree of reflection and theorising, the notion of what a healthy community might be is inevitably complex and contested.

We maintain that a more positive and holistic view of health and wellbeing are warranted; one consonant with the health promotion models discussed earlier. The challenge is to theorise health in ways that can transcend negative views of health as a 'state of absences' and, rather, articulate notions of the potential for individuals and groups to contribute to common wealth, as well as their broad experience of positive place-in-the-world.

The literatures on health promotion offer some guidance for geographers and others to deepen a sense of healthy communities. This body of work takes community as a fundamental variable in attempting to grapple with how to improve the health and wellbeing of populations. However, even the field of health promotion has struggled with suitable definitions of the area, perhaps because of the predominance of medical model formulations of health which persistently invert the notion of health into illness, injury and impairment.

The interweaving of community and place and the historico-political and intergenerational contexts of health require that healthy community be conceptualised in ecological terms. When, in addition, the need to encapsulate the aspirations of communities in cultural, economic and social terms is recognised, the depth of the complexity of the task becomes apparent. Given these acknowledgements of context and complexity, we believe that it would be

too easy to leave reference to healthy communities at the level of rhetoric and avoid the task of more deeply engaging with especially local dimensions of what the contours of a healthy community might be. In Aotearoa, New Zealand we have been offered a local and indigenous framework that we wish to draw upon as a foundation for our contribution to this call to extend and deepen the field through active theorising. First, however, we need to acknowledge the policy-based precedents underpinning our search for a broad and localised understanding of healthy communities.

6. *Te Pae Mahutonga*: A Framework for healthy communities

Te Pae Mahutonga is a framework developed by Durie (1999) that connects dimensions of health to the symbolism of the stars of the Southern Cross, a dominant feature of the southern hemisphere night sky and iconic image in New Zealand. For Durie, its application to health is at least implicitly inspired by the fact that pre-contact navigators used the starts for navigational purposes. When applied to health and well-being, the constellation becomes a set of signposts to signal direction and possibilities for human development. Being linked to a constant geographical presence in the night sky, this model is a concrete, yet metaphorical, link between health and place. By way of rationale our particular histories in Aotearoa New Zealand, especially those of colonisation of the land and the ongoing domination of society by Pakeha, are deeply embedded and implicated in the health and wellbeing of our communities. There are persistent health disparities evident in our national statistics, most notably between Maori and Pakeha (but also between the sexes and to a lesser extent between urban and rural areas) (Crampton et al, 2000). Disembodied statistics often fail to reflect the sense in which these patterns in health disparity are interdependent; that a history of colonisation produces colonised people, that scarcity in one place is linked to excess in another; and that the presence of power requires powerlessness to exist (Smith 1999). There is also the danger that notions of material deprivation are reflexively associated with ill-health, social disconnection and despondency. On the contrary, ethnographic research in high deprivation areas of Northland has revealed that, notwithstanding the material poverty of poor housing, low incomes and few employment opportunities, levels of social cohesion and senses of belonging among Maori communities can be particularly strong (Scott and Kearns, 2000). In a paradoxical sense, a highly deprived community in terms of material goods and services can also be, in some senses, a healthy community.

While *Te Pae Mahutonga* was formulated as a model of dimensions of health for Maori communities, Durie (1999) does not propose it exclusively for Maori. Rather, he leaves open the idea that it could be a useful framework for others to adapt and adopt. Given our conceptualising of the interdependence of the health and wellbeing of populations we believe that a selective incorporation of four of the 'stars' is a useful way of organising thinking about the character of healthy communities. We conceptualise a healthy community as one that promotes *mauriora* (secure cultural identity), *waiora* (environmental protection), *toiora* (heathly lifestyles) and *te oranga* (participation in society). Significantly, these four dimensions loosely map into ideas of place as being a recursive relationship between experienced places (waiora and toiora) and place-in-the-world (mauriora and te orange) (Kearns, 1993). In other words, there is an implicit convergence of these

dimensions of Maori worldview and western constructions of place experience.

We contend that each of these four dimensions of wellbeing can be examined with reference to the four aspects of the environment identified earlier — the political, physical, built and social environment. In other words, well-being can be promoted or inhibited by factors associated with, or embedded in, the ordinary and experienced political, physical, built and social environments. For the sake of brevity, we summarise 16 aspects of a healthy community within the cells of Table 1 below.

	Political environment	*Physical environment*	*Built environment*	*Social/Cultural environment*
Mauriora Secure cultural identity	National and community policies, consciousness and values that nurture cultural difference	Healthy public spaces including forests, waterways and beaches – recreational and traditional catches enhance identity[1]	Construction and maintenance of significant cultural symbols of the built environment (e.g. settlements, *marae*, heritage buildings)	Institutions and networks of inclusion that facilitate the production and maintenance of culture
Waiora Environmental protection	Policies to protect environmental sustainability	Clean air, un-polluted waterways and stable productive soils. Active management for biodiversity	Healthy housing and public buildings. Viable health promoting settlement forms including public transport and space.	Enabling of cultural and spiritual connection of people to places
Toiora Healthy lifestyles	Policies that make healthy choices easy choices (e.g. youth alcohol access, smoke free environments)	Recreational environments for physical exercise; soils that produce nutritious foods	Safe built environments that minimize risk of injury (including roads)	Supportive and inclusive social environments, social norms that are health promoting and foster cultural diversity
Te Oranga Participation in society	Economic and income support policies that reduce socio-economic disparities and enable individuals and families to participate in society	Access to natural environments for sport, recreation, food gathering and other culturally significant forms of participation.	Access to public and private amenities and services that enable participation in family and community events (e.g. education, health, worship, recreation and entertainment)	Inclusion in the customs, activities and relationships of an ordinary social life– voice, choice and access

Durie's two remaining stars –the 'pointers' within his health promotion constellation– are *Nga Manukura* (leadership) and *Te Mana Whakahaere* (autonomy). These additional components of Te Pae Mahutonga offer crucial guidance on how we might move toward the aspirations dealt with in the framework as a whole. Heavy responsibility falls on institutions, leadership and workers –the integrated networks– of health promotion. There is a sense that there is an inertia, or countervalence, toward health-demoting thinking and policy that needs to be overcome or

[2] Hapu were known by the traditional food sources they shared with visitors, e.g., the tuna people

reversed. Planning and active management of resources are needed to achieve and consolidate this new direction. The notion of autonomy (*Te Mana Whakahaere*) acknowledges that self-governance (particularly within a comprehensive framework as indicated above) is inherently health promoting. In this context, the notion is used to signal the importance of the requirement that development and solutions be appropriately tailored to the communities for which they are implemented. There is a strong commonsense appeal to the recognition that fitting the approach to community aspirations and needs is at once enhancing of the sense of wellbeing and more likely to produce positive outcomes than a roll-out of rigid 'one size fits all' campaigns.

Cast in these terms we can see the matrix as articulating a development orientation towards striving for healthy communities that could be flexibly adapted to diverse, culturally mixed community settings within our society. Our case study below is an attempt to illustrate this applicability. It is noteworthy that we have attempted to complete the cells with forward-looking, positive exhortations instead of the indicators framed negatively and influenced by medical models as discussed earlier. However, in crafting a matrix according to aspects of *Te Pae Mahutonga*, we acknowledge that we run the risk of so democratising the influences upon a healthy community that we symbolically relegate the importance of the basic prerequisites to survival. To this extent, we recognise that some aspects of personal health must be prioritised for a healthy community to exist. In other words, we want to emphasise that a fundamental requirement for a healthy community is that the individuals and families that constitute a community have an adequate income to access the housing, amenities and services they need to stay healthy. In the short to immediate term, therefore, the lower left-hand cell (economic and income support policies) are a critical prerequisite to, for instance, individuals and households having the opportunity to enjoy the recreational settings signalled in the previous row (Toiora/Physical Environment). Thus, to maintain well-being, material resources are required before satisfactory inclusion in the customs, activities and relationships of an ordinary social life can be achieved. However, the efficacy of such otherwise subtle aspects of well-being cannot be underestimated. Evidence shows that people who are poor and/or socially excluded have shorter lives and experience a greater burden of illness than people who are materially advantaged and socially integrated.

Our matrix speaks to the way that the health of communities is responsive to policy changes at national, regional and local levels. For example, Coburn (2004) presents data to support the argument that as certain countries adopted more neoliberally-inclined policies through the 1980s and 90s, infant mortality rates in these countries deteriorated relative to countries that retained more universal welfare policies. The enactment and implications of such policies for communities in New Zealand has been comprehensively documented (Le Heron and Pawson, 1996). Similarly, our matrix highlights the way that environmental policies, particularly those that relate to air and water quality, can also profoundly threaten the health of communities. For example, transport-related policies in the Auckland region have contributed to high levels of vehicle emissions and an increase in respiratory related deaths. As the table above depicts, socioeconomic factors are not the sole issues that determine healthy communities. Political decisions in areas such as environmental quality can shape the cultural and behavioural norms of communities.

Rather than providing further descriptions of the matrix, we now illustrate ways in which selective components of it are played out in the context of a case study that reflects on the lives of caregivers of young children in suburban Auckland and invokes links between *Mauriora, Toiora, Te Oranga* and the social environment on Table 1.

Case Study: Diversity in Beachhaven

Within increasingly diverse urban settlements, perceptions of a healthy community is invariably experienced differently according to cultural group affiliation, everyday practices and sites of significance. Our study of Beach Haven is part of a larger investigation of the importance of neighbourhood to caregivers of young children (see Witten, 2004) which sought to identify ways of revealing multiple experiences of place through a methodology that was sensitive to difference, yet anchored in place.

Beach Haven is an identifiable peninsula of North Shore City in the Auckland metropolitan area , with distinctive areas of native bush and an accessible coastline of the Waitemata Harbour. We undertook 32 interviews with parents/caregivers (10 Maori, 10 Samoan, 12 Pakeha) along with 10 key informants living and/or working in the locality. The loosely structured interviews covered participants' experiences of parenting in the locality, perceptions of neighbourhood (people and place), access to and use of community services and facilities, social and community participation and the meaning of neighbourhood and community to participants.

Although not specifically addressing the notion of healthy communities, interview data speaks to shared understandings of the links between place and well-being. Participants talked about the natural environment as well as public spaces such as parks, the beach, wharf and village shops as places of familiarity and collective activity. For many Maori and Pakeha, and, to a lesser extent, Samoan caregivers, these environments contributed to a sense of connectedness and belonging. Community events and festivals as well as more informal meetings with local people commonly occurred at these sites. In this way the significance of the natural and built environments to participant's sense of place in Beach Haven was intertwined with its significance as a peopled environment.

Discourses of place had varying nuances for perceptions of what made Beach Haven a good place to live among the different ethnic groups. Maori participants cite the bush and the water, the parks and the locations of their institutions as important to them but more as sites of participation than markers of belonging. Maori structures and infrastructures, particularly those that centred on children's development and education such as *kohanga reo, kura kaupapa*, a bilingual unit at a local school and Tu Tangata were critical nodes of community, as to a lesser extent was the rugby league club. Possibly either a specific or generalised sense of *turangawaewae* (place of belonging) carried over to locational aspects of belonging but it seems that participation in Maori and other institutions was the more salient feature of Maori participants' sense of connection and well-being.

For Samoan participants there was a strong sense of the familial and cultural connections that constitute community with much less emphasis on the significance of the actual location. Family and friends, often from a church context, were the contacts and networks within which a sense of belonging was constituted.

For Pakeha participants, location –again specified in terms of certain iconic physical features of the area such as bush, water and located amenities –was of paramount importance with the institutions and practices of participation almost taken for granted. As for Maori, preschools and schools were significant as community meeting places and as sites for the production and maintenance of community social relations.

Our research exposes the fact that different groups vary in their uses and understanding of, as well as feelings for, residential neighbourhoods. For all groups, schools were evident as critically important sites of social connection above and beyond their educational function. In terms of urban planning and promoting healthy communities, this evidence signals community-specific contexts which should be nurtured in and of themselves, as well for the potential to be platforms for wider connection into society at large.

7. Conclusion

In this chapter we have attempted to develop a holistic, developmental and future oriented way of thinking about healthy communities that draws on and extends both recent developments in health geography (Gesler and Kearns, 2002) and Mason Durie's (1999) *Te Pae Mahutonga* framework. We have done this in an effort to show the importance of localising more general health promotion frameworks from the international setting to the particular historical and political conditions. The interdependence of the wellbeing of various groups and the need to build theory and applications that can account for their real world interfaces is one of the imperatives of living together in society. The bringing together of the tenets of the different frameworks into a matrix usefully elaborates and cross-references the local and the generic.

While articulated largely in response to the need to localise ideas about healthy communities, our thinking can also be extended into current discourses surrounding notions of sustainability. The conceptualisation of sustainability involves intersections of environmental, social and economic concern which resonates with the holism of post-medical definitions of health that have informed our foregoing discussion. The challenge to researchers, planners and policy makers is to seek ways to translate the holism from policy into practice. We contend that a useful start is to resort to models such as *Te Pae Mahutonga* that can be adapted to re-aggregate, rather than disaggregate, the diverse influences upon healthy communities.

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